Patty C. Collin's thesis on the History of Park View Hospital and School of Nursing

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NOTE ON THE TEXT: *The following is a copy of the body of Collin's thesis, as originally posted by Pheobe A. Pollitt on the Appalachian State University North Carolina Nursing History website (https://nursinghistory.appstate.edu). The following copy does not contain the full breadth of the thesis, and is lacking images, appendices and references.*

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The history of Park View Hospital and Park View School of Nursing

I. Introduction to Research

Nursing has long been defined as both an art and a science. The untrained nurse is as old as the human race; the educated nurse is a recent phenomenon. The art of nursing has gone through many stages and has been an integral part of societal movements. From the Civil War to the past September 11th terrorist attacks, nursing has played a key role in supporting the healthcare needs of people. The term *nurse* has progressed from a term indicating a woman who performed the basic innate human activity of suckling an infant to one describing a person who is part of a highly educated, sophisticated profession. The history of nursing can be traced back to primitive times,Egypt,Persia, Babylonia, Assyria, Palestine, India, China, Greece, and Rome. In the ancient times, women cared for their own. As the nursing concept broadened, nurses also took care of the members of their own tribe. With the development of early civilizations, slaves and servants of households and estates also received care and nursing began to be performed outside the home. The written history of nursing is relatively recent. Pre-Christian records of nursing are fragmentary and scattered; however, records of nursing from the days of early Christianity to present day are continuous. During specific periods in history, nursing was influenced by religion, and nursing was regarded as a calling.

The Dark Period of Nursing

The profession of nursing experienced a dark period from 1550 to 1850. Nursing and hospital conditions were at their worst. Women were recruited from all sources to fill the nursing ranks. During this time, nurses were not professionally educated, and they were often prisoners, prostitutes, or discharged patients. In the early 1800s, hospitals were dreaded institutions, and nurses did not have good reputations. Hospitals smelled due to lack of sanitation. Insects and rodents frequently crawled across the floors saturated with organic material. Disinfectants had not been invented, and people were unaware of the importance of clean, sterile hospital

environments. Nursing pay was poor, frequently supplemented, and often, nurses would take bribes before providing patient care.

Nightingale Revolution

The mid 1800s saw a significant turn in the history of nursing and is referred to as the Nightingale Revolution. On February 7, 1837, Florence Nightingale stated God spoke to her and called her to His service. After providing care to her sick grandmother and taking care of other sick people, she knew this calling was to become a nurse. In order to fulfill her dream of becoming a nurse, Florence Nightingale entered *Maison de la Providence*, the hospitals of the Sisters of Charity inParis in 1853. During the 1800s, there were no official medically structured training programs for nurses. Unlike nursing programs of today, women could become nurses by working at church-owned hospitals. Religious women would teach other women how to nurse the sick. The church-oriented training was not medically based; it had no structured ways of testing or certifying, and women learned through hospital experience (Peach, 1954).

When Florence Nightingale left *Maison de la Providence*, she began visiting hospitals and collecting facts to establish a case for reforming hospitals and nurses. During the Crimean War, she began to educate nurses and doctors on the basic importance of a clean hospital environment.   During the year Florence Nightingale was involved in the Crimean War, the mortality rate at one hospital fell from 42.7% to 2.2%.

After the Crimean War, Florence Nightingale developed the first organized program of training for nurses. TheNightingaleTraining Schoolfor Nurses opened in 1860 as an entirely independent educational institution financed by the Nightingale Fund. TheNightingaleSchoolwas extremely important to nursing. It served as a model for other schools, and it raised nursing from degradation and disgrace to the rank of a respectable occupation for women.

In the early nineteenth century, the status of nursing in theUnited Stateswas not unlike that inEnglandprior to the influence of Florence Nightingale. Large city hospitals were in existence and nurses were haphazardly trained in the hospital. There were few trained nurses and no formal training programs. The Civil War, much like the Crimean War, brought the need for skilled nurses to the attention of government agencies and brought about the first major reforms in nursing in theUnited States. In 1873, the first schools of nursing were started: Bellevue Training School in New York, The Connecticut Training School in New Haven, and the Boston Training School (later the Massachusetts General Hospital Training School for Nurses) (Donahue, 1996).

Committees or boards that had the power to develop the schools created the earliest schools independent of hospitals. They were soon absorbed, however, into the hospitals to which they were attached because of a lack of endowment. In the absence of public or private support, the schools of nursing faced financial problems from the time of their conception. An agreement by the school to give nursing service for the hospitals providing clinical experience was the primary means of overcoming this difficulty. Having a school of nursing became accepted as the most popular and least expensive means of providing nursing care.

Nursing Education inNorth Carolina

North Carolinahad neither hospitals nor trained nurses until after the Civil War. In 1876, St. Peter's Hospital inCharlottebecame the first civilian hospital in the state ofNorth Carolina; in 1891, the Good Samaritan Hospital opened inCharlotteas the first privately funded, independent hospital inNorth Carolinaexclusively for the treatment of African-Americans.   After this time, hospitals began to spring up acrossNorth Carolinaand the need for trained

nurses became apparent. Under the influence of Mary Lewis Wyche, aVanceCountynative and nursing graduate ofPhiladelphia General Hospital,North Carolina's first nursing school opened atRexHospitalinRaleighin 1894. (Wilson & Lefler, 2003).

AlthoughNorth Carolinahad several training schools for nursing, there were no professional standards and no registration of nurses. Anyone who attended a training school for nursing could call themselves nurses without having to complete a competency based licensure exam. Isabel A. Hampton, the first Superintendent of Nurses of the John Hopkins Hospital Training School for Nurses stated, " In the absence of educational and professional standards, I am sadly forced to admit that the term 'trained nurse' means anything, everything, and next to nothing" (Wilson & Lefler, 2003). As the first president of the North Carolina Nurses Association, Mary Lewis Wyche framed a bill in 1902 to provide for the registration of trained nurses. OnMarch 3, 1903,North Carolinabecame the first state in the nation to pass a nurse registration law. Over the next 60 years, numerous nursing programs were started in the state ofNorth Carolina. The majority of these programs were three-year diploma programs offered through local hospitals. The diploma programs were unique in that they taught the art of nursing and required their students to work in the hospital as staff nurses during their training. This is how many hospitals inNorth Carolina avoided financial problems by not having to pay their nursing staff.

The majority of nurses from the early 1900s up until the late 1960s were trained at three-year, hospital based diploma-nursing programs. One well-known diploma-nursing program wasParkView Nursing School Rocky Mount,North Carolina. ParkView Nursing Schools began training nurses when the hospital was established in 1914 and continued until its doors closed in 1969. A pamphlet that was published between 1914 and 1924, which summarized information about theParkViewTraining Schoolfor Nurses, stated the hospital "maintains a register for graduates nurses and will endeavor to obtain competent nurses for all physicians applying for them." It stated the school "is made up of young ladies from the best families in the State, especially selected because of their fitness for the profession." All graduates were required to attend class, complete the required clinical hours, and work as staff nurses atParkViewHospital.

In 1969,ParkViewNursingSchoolwas forced to close it doors. The reasons were increasing costs brought on by the federal minimum wage law; the rising number of Medicare, welfare, and indigent patients; and the requirement of the State Board of Nursing that prohibited student nurses from working without the supervision of faculty. These are only a few of the changes required by the North Carolina State Board of Nursing that have directly affected the quality of health care and nursing education.

Rationale for Study

In March of 2003,North Carolinacelebrated the first century of professional nursing. It is the opinion of many nurses that the public often has a misconception of nursing and nursing history. Many people continue to view nurses as women wearing nursing caps and starched white uniforms whose only purpose is to assist the physician. The nursing field has various components; therefore, it is important for the general public and all disciplines of health care to understand the true concepts of the field of nursing and nursing education. Nurses not only provide support for physicians, but also in the majority of cases, provide the primary care for sickness, injury, as well as health promotion. Nurses have gone from receiving nonstructural nursing education based on hospital experience, to attending formal institutions of learning based on curricula developed by educated health care professionals. Therefore, the purpose of this research is to examine the history of nursing education in terms of one hospital inNorth Carolina.

Significance of Research

Presently, there is very little organized data on the history of ParkView Park View School of Nursing. There is no document that truly captures the historical contribution that Park View School of Nursing has made to the field of nursing. Now thatNorth Carolinahas recently celebrated its 100-year anniversary of the Nurse Practice Act, nursing students, nurses, and the general public are more interested in the history of nursing in Rocky Mount North Carolina. Two early historians of nursing, Lavinia Dock and Isabel M. Stewart, expressed the depth of the gift that nursing history can provide: "No occupation can be intelligently followed or correctly understood unless it is, at least to some extent, illumined by the light of history interpreted from the human standpoint" (Wilson & Lefler, 2003).

Nursing history serves to expand students' thinking, and provides them with a sense of professional heritage. Knowledge of nursing history provides a sense of professional identity. Understanding what other nurses have done for improved health care is essential to the nursing students' professional development. Nursing history can provide insight into problems of today. For example, presently the United States is facing one of the worst nursing shortages in the history of nursing. Through researching the interventions that nurses implemented to combat previous nursing shortages in the 20th century, nurses may learn valuable lessons for addressing the present nursing shortages in the 21st century. Also, it is important for present day nursing students and nurses to have an understanding of the history of how organized nursing education began in the United States.

The social pressures such as the question of which type of nursing degree is the better, (associate or baccalaureate) have shaped nursing and nursing education in the past and persist today in new forms. These challenges are better understood and addressed when nurses are knowledgeable of their nursing heritage. North Carolina has seen many changes in nursing over the last 100 years. Hospitals are no longer dreaded, filthy institutions with untrained nurses. Through the foundation laid down by Florence Nightingale and Mary Lewis Wyche, nurses of today are well educated, and capable of providing safe and efficient nursing care.

Chapter Two of the research will provide an in-depth historical review of the history of nursing and nursing education prior to Florence Nightingale, the Nightingale Revolution, and data on the history of nursing in the United States, North Carolina, and Park View Hospital.

II. Review of Literature

Presently, there is no organized documentation of the history of ParkView Park View School of Nursing. The purpose of this research is to examine the history of nursing education in terms of one hospital. This chapter will review the history of nursing and nursing education from AD 500 to present day. The chapter will also include the contributions of Florence Nightingale, military influences, men in nursing, and conclude with the history of nursing education inNorth Carolina.

Nursing and Christianity: AD 1 - 500

There is very little documented literature about nursing prior to the beginning of Christianity. However, records of nursing from the days of the early Christian workers to the present day are continuous. According to Donahue, Christ's teachings of love and brotherhood transformed not only society at large but also the development of nursing. Under the concept of altruism, nurses during this time were required to perform the following duties: feed the hungry, water the thirsty, clothe the naked, visit the imprisoned, shelter the homeless, care for the sick, and bury the dead (Donahue, 1996).

During the first and second centuries, providing care for the sick and injured was part of the calling for all Christians. Many of the care providers were deacons and deaconesses, who took care of the ill in their home. During this period, no technical preparation was required to perform such a service. Later, the medical care that Christians provided was centered in hospitals or guesthouses that required full-time staff. The care providers were chosen among the widows, virgins, and other members of the church (Stewart, 1996).

Donahue (1996) further stated that the original inspiration of Christians to care for the sick stemmed directly from the teachings of Christ himself. Many instances are cited of Christ's healing the sick and raising the dead by direct intervention without the use of any medicine or treatment. Faith healing, therefore, was a part of Christian belief. In addition, those conditions that would promote natural healing were added and eventually supplied the impetus for the establishment of centers for nursing care. Caring for the sick became an activity especially pleasing to God and through which an individual might inherit "eternal life" (Donahue, 1996).

Donahue (1996) stated that many benefits were derived from the Christian effort, including the development of a humanitarian approach to the care of the sick and poor, and the development of organized nursing services. However, Donahue further explained that as nursing became closely identified with religion and religious orders, strict discipline became a way of life. She stated religion forced nurses to make a strong commitment but a commitment at the expense of money, family, and personal freedom. Those engaged in the nursing work were eventually trained in docility, passivity, humility, and total disregard for self. Unquestioning obedience to the decisions of others higher in rank, usually the priest or physician, was required. Donahue (1996) concluded by stating an individual nurse's accountability, and the personal responsibility for decision making in regard to patient care, was thus bypassed and totally alien in nursing for many years to come.

The first five centuries of the Christian era witnessed the rise of a religious and social movement that enabled the systematic development of organized nursing. The right of single women to acquire a position of usefulness and responsibility was established, thereby opening the door to a respected career in nursing. During the early Christian era, the foundations of the "nurses' calling" and of all modern works of charity were laid (Donahue, 1996).

The Early Middle Ages: AD 500 - 1000

During the Middle Ages, chaos was present as a result of barbarian tribes and extreme moral decay. There were widespread epidemics, natural disasters, and wars. The population declined, crime waves occurred, poverty was abundant, and torture and imprisonment became prominent, as civilization seemed to slip back into semi barbarianism (Donahue, 1996).

Donahue (1996) explained that most women were forced to marry young, often without their consent. Their chief value to society was their breeding power and the ability to manage a home. She was frequently called upon to nurse family and guests or villagers. The lady was in charge of the care of the sick of the manor and was a combination doctor and nurse. She applied first aid, faced surgical emergencies, and had an extensive knowledge of home remedies for all types of illnesses. Medicine was almost entirely in the hands of these women. The number of doctors was small, and only a few of them were located in the manors (Donahue, 1996).

During this period, monks and nuns primarily performed nursing care in the hospitals. Monks did nursing in the men's wards and nuns in the women's wards. There was little concern directed toward the advancement of science, nursing or medicine, and there continued to be no formal training for nurses. The monks and nuns

practiced medicine as well as nursing. Medical treatments consisted of folk and drug lore, mysticism, religious faith, and superstition. Bloodletting, enemas, and leeches were also common (Donahue, 1996).

The Late Middle Ages: AD 1000 - 1500

Donahue revealed that during the late Middle Ages crowed living conditions and increase spread of disease created a need for the establishment of new and different types of orders to care for the sick. The redistribution of the population and urban growth brought nursing out of the institutions and back into the home. During this time period, Donahue reported that medieval hospitals were in place to keep, not cure the patients. The aspect of cure evolved slowly and did not become widespread until the late nineteenth century. Nursing care was mainly custodial duties, and was primarily performed by monks and nuns. As centuries passed, there were not always enough nurses. Hospitals began to put more that one patient in a bed, and the patients were usually dirty and not fed well. Due to the nursing shortage, late Middle Ages were a time when people of low character were beginning to be utilized as nurses. Donahue stated this was a time period in which there was the beginning of a decline in nursing, a decline that would ultimately occur and persist for a long, dreadful time (Donahue, 1996).

The Dark Period of Nursing: AD 1500 - 1850

In 1517, a Protestant Revolt began which started as a religious reform and ended as a revolt. It was a religious movement that resulted in a division of Christianity. During the Protestant Revolt the majority of the hospitals operated by the Catholic Church were closed or controlled by the Protestants. Monks and nuns were driven out of the hospitals in the Protestant countries, which caused a tremendous shortage of nurses to care for the sick and the poor. According to Donahue (1996) hospitals became places of horror, since there was no qualified group to take the place of the nursing religious orders. The most serious consequences occurred inEngland, where Henry VIII suppressed all the religious orders and confiscated the property of some six hundred charitable endowments. Women with no medical or nursing training were recruited to fill the nursing ranks (Donahue, 1996).

The “Dark Period of Nursing,” between 1500 and 1850, saw nursing and hospital conditions at their very worst. Donahue (1996, p. 180) included a brief passage written about hospital conditions during this time period:

The hospitals of cities were like prisons, with bare, undecorated walls and little dark rooms, small windows where no sun could enter, and dismal wards where fifty or one hundred patients were crowded together, deprived of all comforts and even necessaries. In one bed of moderate width lay 4, 5, or 6 sick persons bedside each other, the feet of one to the head of another…. In the same bed lay individuals afflicted with infectious diseases bedside others only slightly unwell; on the same couch, body against body, a woman groaned in the pains of labor, a nursing infant writhed in convulsions, a typhus patient burned in the delirium of fever, consumptive coughed his hollow cough, and a victim of some diseases of the skin tore with furious nails.

During this period, nursing was not an honorable profession. It was universally assumed that the only qualification needed for taking care of the sick was to be a woman. The pay for nurses was poor, and nurses were often kitchen maids, drunkards, discharged patients, prostitutes, or prisoners (Dossy, 2000). In some hospitals nurses were dismissed for abusing the patients. In other hospitals they were reprimanded or dismissed for abuses of various types such as entertaining men at night in the wards, scolding patients, or general patient neglect. Due to the abuse brought about by these unqualified, dishonorable nurses, Donahue (1996) revealed some attempts were made to develop qualifications for nurses or sisters who would function in the hospitals.

Donahue (1996, p.181) also included the first set of structured rules for nurses: Thomas Fuller wrote that the nurse should be:

1. Of middle age, fit and able to go through with necessary Fatigue of her Undertaking.
2. Healthy, especially free from Vapours, and Cough.
3. A good Watcher that can hold fitting up the whole Course of the Sickness.
4. Quick in Hearing, and always ready at the first Call.
5. Quiet and Still, so as to talk low, and but little, and tread softly.
6. Of good Sight, to observe the Pocks, their Colour, Manner, and Growth, and all alterations that may happen.
7. Handy to do everything the best way, without Blundering and Noise.
8. Nimble and Quick a going, coming, and doing everything.
9. Cleanly, to make all she dresseth acceptable.
10. Well-tempered, to humour, and pleas the Sick as much as she can.
11. Cheerful and Pleasant; to make the best of everything, without being at nay time cross, Melancholy, or Timorous.
12. Constantly careful, and diligent by Night and by Day.
13. Sober and Temperate; not given to Gluttony, Drinking, or Smoking.
14. Observant to follow the Physician's Orders duly; and not be so conceited of her own skill, as to giver her own medicines privately.
15. To have no Children, or other to come much after her.

Donahue (1996) wrote that in 1633 a secular nursing order called Les Filles de Charite, or the Sisters of Charity was founded. Under this nursing order, young single girls were recruited; they were required to be intelligent, refined, and sincerely interested in the sick and the poor. An educational program was established to include experience in the hospital, home visits, and care of the sick. This was the beginning of the Sisters of Charity, where Florence Nightingale would attend in 1853. The Sisters of Charity, however, was under no written rule, nor did it offer any type of structured educational nursing training. All training was based on experience, and a weekly lecture on spiritual training. The sisters took charge of hospitals, asylums, and homes for the insane. They taught in schools, served during wars, and offered care to lepers. Donahue, (1996) concluded that the modern principles of visiting nursing and social service were sown during this time.

The Nightingale Revolution

The Sisters of Charity did provide some humanitarian efforts in the treatment of the ill; however, between 1500 and 1860, the prevailing thought that nursing was a religious rather than an intellectual occupation prevailed. Because of this belief, scientific improvement was not necessary. Hospitals remained dreaded institutions, and intelligent persons could not be persuaded to undertake nursing in the offensive hospitals. Donahue (1996) stated that even the Sisters of Charity religious orders came to a complete standstill professionally because of a persistent sequence of restrictions from the middle of the sixteenth century. Between 1500 and 1860, when a woman could no longer earn a living from gambling, she might become a nurse. There was little organization associated with nursing and no social standing. No one would enter nursing that could possibly earn a living in some other way (Donahue, 1996).

However, in the mid 1800s, one woman would forever change the field of nursing. During the mid nineteenth century, Florence Nightingale caused the transition of the *Dark Period of Nursing* to the period of M*odern Nursing.*

Florence Nightingale was born inFlorence,Italy, in 1820. In the early nineteenth century, girls were not usually sent to school. However, by the age of 17,Florencehad mastered several ancient and modern languages. She was knowledgeable in the areas of literature, philosophy, religion, history, science, and math. Also, during this time, women were not valued as educators. For example, Florence Nightingale tutored a young man in mathematics for an examination atSandhurst; however, people stated he would be laughed out of school if it got out he had been educated by a girl (Peach, 1954).

OnFebruary 7, 1837,Florencestated God spoke to her and called her to His service. After providing care to her sick grandmother and taking care of other sick people in the valley Wellow, she knew this calling was to become a nurse. As stated earlier, in the 1800s, hospitals were dreaded institutions, and nurses did not have good reputations. Therefore, Florence Nightingale's parents became furious when she announced she wanted to study nursing. After Florence Nightingale announced her desire to become a nurse, it would be eight years before her parents would agree to her request. Her parents wanted her to become an accepted lady of society and marry. During these eight years, Florence worked in secret. She wrote notebooks filled with facts about hospitals and poor sanitary conditions. She often visited the sick in secret (Dossy, 2000).

During the 1800s, there were no official medically structured training programs for nurses. However, in 1853, Florence Nightingale entered *Maison de la Providence*, the hospitals of the Sisters of Charity. Unlike nursing programs of today, people could become a nurse by working at church-owned hospitals. Religious women would teach other women how to nurse the sick. The church-oriented training was not medically based; it had no structured ways of testing or certifying; and women learned through hospital experience, and by assisting the doctors.

When Florence Nightingale left *Maison de la Providence*, she began visiting hospitals and collecting data to establish a case for reforming hospitals and nurses. After collecting her facts, Florence Nightingale became the first true nurse educator. She provided education on better sanitary practices and ways to reform conditions for hospital nurses.

Soon after completing her training, England and France had declared war on Russia. In September 1854, the allied armies landed in Crimea. During the Crimean War, a war correspondent wrote about the horrible conditions of military hospitals and the inhuman treatment of wounded soldiers. Because of the positive reputation Florence Nightingale had received through her data collecting and hospital reform efforts, Sidney Herbert, the Secretary of War, appointed Florence Nightingale the Superintendent of the Female Nursing Establishment of the English General Hospitals in Turkey. Florence met resistance from her country and among the army doctors. Some people in England said women could not stand the bad weather in Turkey, and instead of nursing the wounded soldiers; they would all become ill and require nursing themselves. However, Florence Nightingale took 40 nurses directly to the Barrack Hospital in Turkey with a mission to improve hospital conditions and to prove the value of women as nurses (Peach, 1954).

According to Smith (1951) upon arrival to the Barrack Hospital, the chief army doctor, Dr. John Hall, resisted Florence Nightingale and her nurses. He arranged for Florence and the nurses to live in an old tower overrun with rats, with no heat or furniture. Little did the army doctor know, Florence Nightingale was one of the most determined women of her time.

The Barrack Hospital was a bare, filthy building with no beds that had patients lying on the floor stretched out for 4 miles. Wounded soldiers lay half naked on the floor, wrapped in blankets saturated with blood and human waste. There were no operating tables, and the majority of men died not of their wounds, but of diseases they contacted as a result of being in the hospital. Surgeons did not wash their hands or change their gowns between surgeries. The wounded were put in the same areas as men with infectious diseases. There was not an organized kitchen, and the food was barely cooked and cold before the men ate it (Smith, 1951).

Florence Nightingale immediately began hospital reform efforts. She began to educate the nurses and doctors on the basic importance of a clean hospital environment. She and the other nurses began scrubbing the floors, washing the linens, and preparing clean bandages. Realizing the importance of a balanced diet for adequate wound healing, Florence reorganized the kitchen and had a garden planted, so green vegetables could be grown. She taught the importance of keeping injured patients separate from those with contagious diseases. Through her research, she realized that where men were placed in the hospital had a direct effect on their survivability. She discovered that the Barrack Hospital stood in a sea of decaying filth that housed rats. Every breeze would blow poisonous gases through the pipes into the wards where the sick were laying. Florence immediately put into action the efforts of hospital reconstruction.

Florence Nightingale realized that patients still needed to be assessed and cared for during the night. She developed the idea of patient rounds. At night, she would take her lantern and walk through the Barrack Hospital and assess the condition of the soldiers. This is how she received the title, “Lady with the Lamp”. It has been documented in several sources that soldiers were so grateful of her presence that they would kiss her shadow as she walked by (Dossy, 2000).

During the year Florence Nightingale was at the Barrack Hospital, the mortality rate fell from 42.7% to 2.2%. Florence provided education regarding the importance of caring not only for the physical needs of the patient, but also for the mental needs. She organized the development of a small reading and recreation room. She instituted the idea of separating the operating room from direct sight of the soldiers. This would spare the soldiers from seeing and hearing the pain of surgery. Florence Nightingale taught nurses that patients should not die alone. When a soldier was dying, a nurse would be at his side to hold his hand. Through her successful efforts, the doctors at the Barrack Hospital began to depend on Florence Nightingale. By June 16, 1856, the last patient had left the Barrack Hospital. Between 1854 and 1856, Florence Nightingale had brought about a revolution in nursing (Dossy, 2000).

The last major accomplishments of Florence Nightingale dealt with the implementation of structured educational programs for nursing and her statistical achievements. Florence realized she must produce a new type of nurse with organized medical training. After the Crimean War, Florence received 45,000 lbs to start a training school for nurses. Under her leadership, the students received medical education from the medical staff and surgeons, and were required to pass both a written and oral examination. Florence Nightingale also developed an educational program for training midwives. By 1887, sixteen hospitals employed nurses that had been trained at the Nightingale School. Nightingale-trained nurses went to the USA, Sydney, India, Ceylon, Germany, and Sweden. Nursing schools modeled after the Nightingale Training School was established in Edenborough, Westminster Hospital, and Marylebone Infirmary (Peach, 1954).

Florence Nightingale was probably the first person to use statistics in the medical field. Florence drafted a model statistical form, which made it possible to know the relative mortality in different hospitals. These forms were well received and adopted in most London hospitals. In 1867, Florence discovered that no reliable statistics for childbirth mortality existed. For three years, she collected and analyzed facts and discovered that hospitals had a higher mortality of babies than babies born at home. Her conclusion was that the death rate at home was lower because only one separate delivery occurred. However, in the hospital, several deliveries could occur in

one room, resulting in contamination. Thus, Florence Nightingale taught the importance of separate rooms for labor and delivery (Dossy, 2000).

Due to the long-term effects of catching Crimean Fever, Florence Nightingale remained an invalid most of her life. However, she worked from her bed 16 to 17 hours a day. She wrote several books and continued to produce medical statistics. Florence Nightingale died at the age of 90, at home in London in 1910.

The Nightingale Plan in America

Following the Civil War, the interest in nursing education became apparent. In 1873 the famous trio of schools that encouraged the steady progress of nursing evolved: Bellevue Training School in New York City on May 1, the Connecticut Training School in New Haven on October 1, and the Boston Training School on November 1. These schools were initially based on the Nightingale model, but they were soon forced to deviate and follow a different path. The alterations that occurred greatly influenced the direction of nursing in America (Donahue, 1996).

Committees or boards that had the power to develop the schools created the earliest schools independent of hospitals. They were soon absorbed, however, into the hospitals to which they were attached because of lack of funds. According to Donahue (1996) this factor proved to be the greatest weakness in the system, since many hospitals soon discovered that schools could be created to serve their needs and a valuable source of almost free labor could be obtained (Donahue, 1996).

Donahue (1996, p. 273) included the following concerning nursing schools within hospitals: In the absence of public or private support, the schools from the time of their inception faced financial problems of major proportions. An agreement by the school to give nursing service for the hospitals providing clinical experience was the primary means of overcoming this difficulty. This type of apprenticeship agreement was the factor promoting hospitals to establish schools on their own initiative. Having a school of nursing became accepted as the most popular and least expensive means of providing nursing care. The hospital was the master and the student nurse was the apprentice, with the latter giving free labor to the former in return for informal training in the traditional manner.

Donahue further added that nursing care became the major product dispensed by hospitals. The real function of the school of nursing became not education, but service. In addition, no policy for control of the numbers of nursing schools or the standards for admission and graduation was established or accepted. Consequently, a proliferation of nursing schools occurred. During the first decade of the twentieth century close to seven hundred new nursing schools were established. All school functions were ultimately placed under the control and general direction of hospital authorities (Donahue, 1996).

Following the Civil War efforts were made to improve hospitals and training programs for nurses. To assist in this effort, Dr. Gill Wylie of Bellevue Hospital voluntarily visited England to study schools established under Florence Nightingale, who had identified the essentials of a good training school. The following is a sample of some of those essentials:

A year’s practical and technical training in hospital wards, under the trained head- nurses who themselves have been trained to train.

The training of probationers should be as much a part of the duty of the head- nurse as directing the under-nurses or seeing to the patients.

To tell the training, you require weekly records…kept by the head-nurses of the progress of each probationer in her ward.

Clinical lectures from the hospital professors…elementary instruction in chemistry…physiology…and general instruction on medical and surgical topics; examinations, written and oral, at least four of each in the year, all adapted to nurses; as also lectures and demonstrations with anatomical, chemical and other illustrations, adapted especially to nurses.

A good nurses' library of professional books, not for the probationers to skip and dip in at random, but to make careful use of, under the medical instructor and class-mistress…

The authority and discipline over all the women of a trained lady-superintendent…who is herself the best nurse in the hospital, the example and leader of her nurses in all that she wishes her nurses to be…

Accommodation for sleeping, classes, and meals; arrangements for time and teaching and work; surroundings of a moral and religious, and hard-working and sober, yet cheerful tone and atmosphere, such as to make the training-school and hospital a "home' which no good young woman of any class need fear by entering to lose anything of health of body or mind; with moral and spiritual helps, and an elevating and motherly influence over all, such as to make the whole place which will train really good women, who can withstand temptation and do real work, and neither be "romantic' nor "menial" (Donahue, 1996, p. 275).

History of Nursing and Nursing Education in the United States

At the turn of the century, nurses in the United States had few choices when they finished nursing school. They could work as private duty nurses in patient's homes or in hospitals as superintendents or head nurses. Because student-nurses performed the nursing work in hospitals, hospitals had no need to hire more than a few supervisory graduate nurses. When public health nursing and visiting nursing associations were established in the 1890s, they offered graduate nurses an additional opportunity for paid work and self-sufficiency. But for the large majority of graduate nurses, private duty nursing was the predominant form of available work (Schorr, 1999).

The stock market crash of 1929 resulted in the same serious unemployment for nurses as for the rest of the country. There was a huge oversupply of nurses and few patients could afford the small fee of a private duty nurse. In 1932, the American Nurses Association launched a campaign to promote hospitals' hiring of graduate nurses for general duty work. During the depression, many nurses were willing to work in hospitals for room, board, and laundry. During the depression years, many nurses recognized the need for improvement in the education of nurses, the distribution of nursing services, and the welfare of those in the profession. In 1934, the final report of the Committee on the Grading of Nursing Schools gave impetus to these changes. In the decade of the thirties, 400 hospitals and 600 hospital nursing schools were closed (Schorr, 1999).

Schorr included that hospital insurance plans grew in tremendous popularity throughout the 1930s, which enabled people to pay their medical expenses and supplied a solution to the empty bed problem that could send

hospitals into bankruptcy. By the end of the decade, hospitals came to be seen as necessary institutions in every community, and nurses were a vital part of their operation.

Educational Shifts in Nursing Education History: Late 19th Century

The Bellevue Hospital Training School for Nurses was founded in May, 1873, and five student's enrolled in the first class. The program was for one year, but the students were required to remain a second year in service. The students received only occasional lectures; the majority of time was spent in practical work through which they gained experience. They received ten dollars per month after completing a probationary period of one month (Donahue, 1996).

According to Donahue (1996) initially Bellevue Hospital Training School wore no uniforms, but after the first year the training school committee decided that a standard uniform should be adopted. Donahue added that this created a stir among the nurses, who were reluctant to wear uniforms. (No nurse in America had ever worn a uniform.) The committee granted Euphemia Van Rensselaer, one of the nursing students with a distinctive family name and social position a two-day leave of absence from Bellevue. She returned in uniform, apron, and cap that had been made especially for her. Her tailored uniform consisted of a long blue seersucker dress with white apron, collar and cuffs, and a white cap. Within a week every nurse was wearing the uniform, which eventually became the mark of a Bellevue nurse.

These early schools proved their value, and by 1879 there were eleven training schools in the United States. Active renovation in hospitals and the creation of new ones occurred between 1873 and 1895. According to Donahue, the function of the hospitals slowly changed from refuges of the destitute to institutions for the care of the sick and injured. The value of trained nurses had finally been proven, and this resulted in a growing demand for trained nurses (Donahue, 1996).

During the 1890s, hospital authorities gradually recognized the advantages to be gained from retaining a ready supply of inexpensive labor through the utilization of student nurses. Between 1890 and 1900, approximately four hundred training schools for nurses were established. The absence of uniformity in content and length of program resulted in nurses with different skills and abilities. Because of this, between 1890 and 1902, the need to establish legal regulation over nursing was instituted.

Educational Shifts in Nursing Education History: Early 20th Century

In 1901, New York, Virginia, Illinois, and New Jersey, respectively, was the first state associations to organize legal control over nursing education. In 1903, North Carolina was the first state to enact a registration law. By 1909, thirty-three state associations were in existence, twenty-four having attained nursing licensure. Twenty years after enactment of the first laws, legislation regulating nursing was operative in forty-eight states. "Registered nurse" was the title incorporated into most of the laws, and almost all provided for the establishment of state boards of examiners (Schorr, 1999).

Schorr stated that overall; the establishment of nurse practice acts was highly productive. The early laws upgraded nursing school requirements, lengthened the program of study, and raised the standards of nursing education in the United States. However, limitations of the early state board of examiners became apparent. The absence of guidelines for validating competency compromised the test. Nurses preparing the examinations were often inexperienced in test question construction, and, with each state administering it own examination, reliability varied from state-to-state. By 1928, nursing leaders began discussing the feasibility of forming a national board

of examiners whose members would create a standard qualifying examination acceptable to all state boards. The Council of State Boards in Nursing was begun as a result of those discussions (Schorr, 1999).

Schorr (1999) stated after the World War I, health care in the United States was disorganized and nurses were in short supply. Many graduate and student nurses had themselves fallen victim to the great influenza epidemic of 1918. Hospitals were still recovering from the war and the influenza outbreak and were trying to rebuild. According to Schorr, to meet these needs and to ensure a low-cost ready supply of caregivers, hospital training schools began forming at an alarming rate. With only a small percentage of hospital budgets being allocated for the schools, the quality of instruction and training materials was low, and many students were graduating with an inadequate education. Critics at the time argued that nursing education could not advance until schools were removed from hospitals and assumed control over their own finances.

According to Schorr (1999), in 1926, the Committee on the Grading of Nursing Schools was organized and financed with a $93,000 grant from Frances Payne Bolton, who sat on the committee and had endowed the new school of nursing at Western Reserve University in Cleveland, Ohio in 1924. The group focused on the supply and demand for nurses, a job analysis of what nursing entailed, how students should be prepared, and an evaluation of the quality of existing schools of nursing. *Nursing, Patients, and Pocketbooks,* published in 1928, indicated that there was an oversupply of nurses who were inadequately and unevenly trained, and significantly underpaid.

Due to the nursing shortage in the late 1940s, controversy developed regarding whether nursing education should go the collegiate route. Kalisch and Kalisch (2004) stated that Dr. Frank Lahey, former president of the American Medical Association (AMA), charged that nurses were “legislating and educating themselves out of jobs” (Kalisch and Kalisch, 2004, p. 330). However, Eunice D. Johnson, director of the nursing school of St. Luke’s Hospital, New Bedford, Massachusetts, maintained, “you can never overeducate a nurse” (Kalisch and Kalisch, 2004, p. 330).

Kalisch and Kalisch (2004, p. 331) included another comment from Edith W. Bailey, administrator of the Canonsburg General Hospital in Canonsburg, Pennsylvania:

> The nurse attending universities and colleges insist only on supervising---no physical work…Not everyone is fitted for supervising---and strangely enough, a sick person doesn’t give a hang whether his nurse possesses a B.A. or B.S. The root question is “Can she make him comfortable?”

According to a postwar survey made by the American College of Surgeons (ACS), less expensive nursing care was needed. The survey revealed that the quantity of nursing was 50% of the total need and that the quality had deteriorated about equally. Eighty-four percent of the replies stated that, with few exceptions, auxiliary help could meet the needs of the sick. On December 20, 1946, the ACS advised hospitals to admit and utilize the assistance of auxiliary nursing aides. In addition, approved hospitals should provide training for such vocational nurses by means of short courses (Kalisch & Kalisch, 2004).

Kalisch and Kalisch (2004) stated that many believed that the registered nurse represented too large an investment in education for some of the tasks she was given to perform. One study showed that of 150 practices and procedures involved in nursing care, only 35% needed to be done by a registered nurse, whereas 65% could be performed by a practical nurse.

The American Nurses Association (ANA), and the National Organization had approved the term practical nurse for Public Health Nursing. A practical nurse was defined as a person trained to care for sub acute, convalescent, and chronic patients requiring nursing services at home or in institutions. She worked under the direction of a licensed physician or a registered professional nurse and gave household assistance when necessary (Kalisch & Kalisch, 2004).

The first school for training practical nurses had been organized in 1897. By 1930, only 11 schools had been established; but between 1930 and 1947, 25 more were opened. Most of the early practical-nurse schools were attached to hospitals and to institutions for chronic, crippled, aged, or mentally ill patients. Some training programs had been organized under the direction of the YWCAs and other private institutions and agencies. The duration of the courses ranged from 9 months to 1 year. The greater proportion of time spent in the first part of the course involved class work. The latter part was devoted largely to practical hospital experience gained under immediate medical and nursing supervision. Graduate nurses were used as instructors and supervisors (Kalisch & Kalisch, 2004).

A postwar movement in nursing that greatly improved standards in nursing schools was the development of the State Board Test Pool. During the late 1930s, state board examinations had generally been poorly constructed and unreliable. Questions such as the following were asked in a test on hygiene; name the six essentials for personal hygiene; name two health essentials for a student nurse; and name two organizations that guard public health.

According to Kalisch and Kalisch (2004), in December 1942 at an emergency conference on state boards, the Subcommittee on Tests of the committee on State Board Problems of the National League of Nursing Education had met and recommended that the league assist states in adopting machine-scored examination questions and implement the proposed plan of developing prepared state board examination "for the use of all states in order to have more valid and reliable sets of examination questions and to have these available for more frequent examinations" (Kalisch & Kalisch, 2004, p. 346 and 347).

The objectives that the committee set up and that the state boards of nurse examiners approved for the State Board Test Pool were as follows:

> To provide objective tests of nursing competency, which will enable each state board of nurse examiners to discover the level of ability of each candidate and the average for each school in the state, and for the state as a whole, in comparison with the level of all other candidates tested, and the average for each other school and state.
>
> To develop improved tests of nursing ability and work towards a comprehensive test battery of high validity and reliability. To study nursing ability, as revealed in the examinations, in order to arrive at a clearer concept of the minimum level of competency as well as the average level of expectancy of professional nurses.
>
> To secure data which will be of help to the state boards of nurse examiners and the schools of nursing in improving the level of nursing preparation. To lighten the burden of busy state boards of nurse examiners by serving as their agent in preparing and scoring the licensing examinations. (Kalisch & Kalisch, 2004, p. 347)

State boards were asked to submit sample questions to the Committee on Nursing Test, which selected those judged most suitable. The examinations were then set up for machine scoring. Within one year, by January 1944, the test pool was in operation and six states had agreed to use the examinations (Kalisch & Kalisch, 2004).

Kalisch and Kalisch stated when the test pool was initiated in 1944, the licensing examination had included 13 test: anatomy and physiology, chemistry, microbiology, nutrition, and diet therapy, pharmacology and therapeutics, nursing arts, communicable disease nursing, medical nursing, nursing of children, obstetric and gynecologic nursing, psychiatric nursing, surgical nursing and social foundations of nursing. By 1949, the number of test had been reduced to six: medical nursing, surgical nursing, obstetrical nursing, nursing of children, communicable disease nursing, and psychiatric nursing. Kalisch & Kalisch further added that each test included questions designed to evaluate the candidate's understanding of principles of physical, biologic, and social sciences, as well as questions designed to test nursing skills and abilities in a given clinical area. The questions were also designed to test candidates' abilities to apply knowledge gained through classroom and clinical experience.

According to Kalisch and Kalisch (2004), growth of and participation in the State Board Test Pool was rapid. Within 5 years, from January 1944 to March 1, 1949, this service expanded from the original 6 states to 41 states. During 1950, the last of the 48 states joined the State Board Test Pool, and nursing became the first profession for which the same licensing examination was used throughout the nation, the District of Columbia, and Hawaii.

Educational Shifts in Nursing Education History: Last Half of the 20th Century

The 1950s brought about much debate over the quality of nursing education in the United States. Due to the nursing shortage, a need was identified to shorten the length of the three-year diploma-nursing program. This brought about the implementation of the two-year associate degree-nursing program. According to Kalisch and Kalisch (2204), a project aimed at developing nursing education programs in junior and community colleges was announced in January 1952 by Louise McManus, director of the Division of Nursing Education at Teachers College, Columbia University. She explained that the purpose of the experiment was to determine if a 2-year program, which would prepare bedside nurses for beginning general-duty positions, was feasible. McManus believed such an approach would help reduce the critical shortage of nurses throughout the nation by producing more nurses faster, and help move nursing education into the overall system of American higher education.

McManus stated that nursing education was largely outside the general system of education in the United States and, unlike education for other professions, had not had the benefit of research. She affirmed that the current system of nursing education had failed to produce the required number and types of nurses. During this time, ninety percent of the nation's nursing schools were owned and operated by hospitals. McManus included that their programs were mainly of the apprentice type, directed primarily at the immediate care of patients, without regard for the community and academic experiences that the modern nurse should receive. She stated further that the 3-year diploma nursing programs included repetitive practices believed to be considerably in excess of that needed for efficient and effective learning (Kalisch & Kalisch, 2004).

Seven community junior colleges were selected for the 5-year research project to develop and evaluate associate-degree nursing education. As these programs were established, general education accounted for one third of the total curriculum, whereas, nursing courses accounted for about two thirds. Of the nursing portion, 75% was clinical practice. Emphasis was placed on giving the student as much experience as possible through careful planning and instructional supervision (Kalisch & Kalisch, 2004).

Kalisch and Kalisch (2004) concluded that in 1958, the results of the 5-year study indicated that the 2-year curriculum could prepare a registered nurse and that the program could become an integral part of a total college. One hundred ninety-two associate-degree graduates had taken state board licensing examinations by then, and 91.7% of these students passed the licensing exam the first time. Kalisch and Kalisch further included that in nursing programs of all types, the figure was 90.5%. According to the study findings, associate-degree graduates were found by head nurses to be as good as or better than most of the graduates with whom they worked in 80% of the cases.

Kalisch and Kalisch (2004) pointed out that diploma nursing programs in the hospital nursing schools had always been, and still was, the backbone of nursing education, but changes had to be made if this form of nursing education was to survive. Ruth Sleeper of Massachusetts General Hospital stated she believed in the value of the diploma program but warned that those responsible for the 3-year nursing schools must make many changes if the diploma programs were to be respected by the country's educational system. Unless changes were made, she said, "the hospital school will not continue to attract desirable candidates in sufficient numbers and a new system of preparing our nurses will be found" (Kalisch & Kalisch, 2004, p. 884).

Schorr & Kennedy stated there was great controversy over where, why, and how should a nurse be educated. Questions include should nursing education take place in the traditional diploma school, an associate degree program, or in a baccalaureate program (Schorr & Kennedy 1999). These concerns brought about the implementation of the National Committee for the Improvement of Nursing Services. Early work of this committee consisted of the collection of factual information about nursing school programs and the interim classification of schools. This was to precede the development of a more comprehensive accreditation system and program. A questionnaire was used, and each of the participating schools was evaluated according to criteria long accepted by the profession. The schools were classified according to a total score obtained by the weighing of the various criteria of administrative policies, financial organization, faculty, curriculum, clinical field, library, student selection and provisions for student welfare, and student performance on state board examinations. In 1950 the findings were published in *Nursing Schools at the Mid-Century* and provided a method for schools of nursing to evaluate their programs (Donahue, 1996).

The 1960s was a time of financial deficits for diploma nursing programs. The pattern of nursing education had remained the same: apprentice-type financing, which hospitals had formerly exchanged for apprentice-type training. According to Kalisch and Kalisch (2004), the cheap-labor component of the traditional hospital system had virtually disappeared. Higher standards had pushed almost all diploma programs far into the red. The outdated idea, still almost universally applied to fiscal practice, was that the student nurse should pay for their education through service to patients.

The era of 1953 to1964 is called the "Transitional Stage of Educational Advancement in Nursing" (Donahue, 1996, p. 426). According to Donahue (1996), it was during the eleven years of the transitional stage that master's level was recognized as the advanced level of nursing education. The National League sponsored a conference on graduate education for Nursing (NLN) in 1954 and 1955. Guidelines were formulated for organization, administration, curriculum, and testing, and a subcommittee on Graduate Education in Nursing was created. The emphasis in content at the master's level moved from both clinical and functional role preparation in all programs for teachers, administrators, and clinical specialists to the elimination of double preparation in the late 1960s, as clinical specialization became extremely popular (Donahue, 1996).

From 1956 to 1962, the number of baccalaureate nursing programs increased from 161 to 178, and the average enrollment in these programs increased from 116 to 132. Kalisch and Kalisch (2004) however revealed that despite the increase in number and size of baccalaureate programs, there was not a sufficient increase in the number of graduates from master's programs who were preparing for college teaching.

In 1961, the surgeon general of the U.S. Public Health Service appointed a special Consultative Group on Nursing to advise him on nursing needs and to identify the appropriate role of the federal government in ensuring adequate nursing services for the people of the United States. A report entitled *Toward Quality in Nursing* was written that identified the major problems facing the nursing profession. The following were listed as concerns regarding the nursing profession: (1) too few schools were providing adequate education for nursing; (2) not enough capable young people were being recruited to meet the demand; (3) too few college bound young people were entering the nursing field; (4) more nursing schools were needed within colleges and universities; (5) the continuing lag in the social and economic status of nurses discouraged people from entering the field and remaining active in it; (6) available nursing personnel were not being fully used for effective patient care, including supervision and teaching as well as clinical care; and (7) too little research was being conducted on the advancement of nursing practice (Kalisch & Kalisch, 2004).

In 1964 a program of federal aid for professional nursing education was proposed entitled H.R. 10042, the Nurse Training Act of 1964. Congressman Oren Harris of Arkansas introduced the bill, incorporating White House proposals for nursing school construction grants as well as for student loans and scholarships. The Senate approved the House-passed version of the Nurse Training Act of 1964 on August 12, 1964. When approved and signed by President Lyndon Johnson, the 5-year legislation authorized $283 million for five programs and an additional $4.6 million for administration of the programs. Ninety million dollars was authorized for construction of nursing facilities, including new renovated, or replacement buildings. (Kalisch & Kalisch, 2004).

According to Schoor and Kennedy (1999), in 1965, the ANA Board adopted the Position Paper on Education for Nursing, which called for baccalaureate education for future practitioners and proved to be explosive. The most controversial element of the paper was the identification of “professional” nursing practice with baccalaureate education and the term “technical” nursing practice with diploma and associate degree education. Schoor & Kennedy stated that this controversy continues to this day.

Kalisch and Kalisch (2004) revealed that the trend in nursing education away from diploma schools and toward colleges and universities became even more pronounced during 1966. Statistics gathered by the National League for Nursing (NLN) indicated that the number of diploma programs had fallen from 821 in 1965 to 797 in 1966. However, associate-degree and baccalaureate programs had increased, respectively from 174 to 218 and from 198 to 210. Kalisch & Kalisch (2004) further added that the changing pattern in nursing education was reflected in student admission data. In 1966, diploma programs admitted 64.1% of the total 60, 701 students newly enrolled in nursing programs. Associate-degree programs showed a marked increase in students, admitting 14.2% of all nursing students. Total admissions to baccalaureate programs increased from 21.7% (Kalisch & Kalisch, 2004).

Donahue stated that during 1964 to 1975, Master’s level education in nursing matured and became an important credential for nurses in leadership positions during these years. Increased interest in research and an expanding number of graduate programs in clinical specialties occurred. Kalisch and Kalisch (2004) reported this time period also saw the birth of the nurse practitioner. The educational preparation for a nurse practitioner was designed to teach professional nurses to make sophisticated clinical judgments on conditions of acutely ill or chronically ill adults and children, and to perform adequately as primary practitioners in adult and childhood emergencies (Kalisch & Kalisch, 2004).

According to Kalisch and Kalisch (2004), by the late 1960s and early 1970s, the nurse practitioner had attained national visibility to consumers, other health professionals, and legislators. The nurse practitioner differed from the traditional nursing model in the autonomy of practice patterns, status in the provision of health care, and in relationship to patients, physicians and health care agencies.

During the 1970s, the number of diploma-nursing programs decreased at a rate of approximately 30 to 40 programs each year. This decrease was believed due to nursing students' desire to attend institutions that awarded academic credit. The decline was also attributable to the costliness of operating an educational program in a hospital in which income for the operation of the school was largely derived directly or indirectly from patients' revenue (Kalisch & Kalisch, 2004).

As of 1982, there were 1432 programs of nursing education in the United States: 288 leading to a diploma, 742 to an associate degree, and 402 to a baccalaureate degree. Kalisch and Kalisch (2004) stated that during the 10 years from 1985 through 1994, the supply and demand for nurses fluctuated. An American Hospital Association (AHA) survey taken in 1987 found that 79% of hospitals needed more nurses. More than 10% of hospitals turned to hiring foreign nurses when they could not find an adequate supply from the United States.

During the height of the nursing shortage in the 1980s, the American Medical Association (AMA) determined that because the inadequate supply of nurses was precipitating a health care crisis, the time had come to introduce a new type of bedside-care giver. The AMA introduced the idea of the Registered Care Technologist (RCT). Applicants would need a high school diploma and would earn $5 to $7 per hour while training. Nine months of preparation would lead to the basic RCT, with and additional 9 months required to become an advanced RCT. Kalisch & Kalisch included that Basic RCTs would transport patients, care for wounds, and learn some higher-level skills, such as administering oral medications under supervision. Advanced RCTs would learn to administer routine intravenous medication under supervision, care for ventilators and cardiac monitors, and recognize changes in patient status (Kalisch & Kalisch, 2004).

Kalisch and Kalisch stated that enormous opposition to the RCT proposal came from the professional nursing associations as well as the American Osteopathic Association. As a result of this pressure, only one pilot program was initiated, at a Kentucky nursing home, and the first class of RCTs apparently never completed their training and certification.

In 2003, registered nurses remained the largest single group of health care providers numbering over 2.7 million. The current RN work force includes about 25% with diplomas, 34% with associate degrees, 31% with baccalaureate degrees, and 10% with master's or PhD degrees. According to Kalisch and Kalisch (2004) one third of all students enrolled in BSN programs were associate-degree or diploma-prepared RNs acquiring the BSN, these students represented less than 3% of all RNs without the BSN. Only about 16% of the RNs prepared initially at the associate-degree level were acquiring a baccalaureate or higher degree in nursing. Fewer than 60 hospital-owned diploma programs remained from the over 2500 such programs that had existed back in the late 1920s. Presently, there are slightly fewer than 900 associate-degree programs in the United States, and they account for over 60% of the new entry-level nursing graduates (Kalisch & Kalisch, 2004).

Two million RNs dominate the health care industry; however, the growth factor has slowed to 5.4% increase from 1996 to 2000. Kalisch and Kalisch (2004) revealed this was the lowest rate of increase since the federal government had been conducting surveys of the nursing profession back in 1980. The survey results from the year 2000 showed that the average age of nurses continued to rise, while the rate of new nurses entering the profession continued to drop. Kalisch and Kalisch concluded that the projected shortage threatened the health of the nation and the integrity of the nursing profession.

For the first time in the history of American nursing, there is widespread disillusionment and dissatisfaction with the wages, salaries, and working condition associated with active service. RNs themselves are now discouraging friends, relatives, and students from going into the field and admitting to others that they made the

wrong career choice, as well as advising recent graduates to escape from bedside care as quickly as possible (Kalisch & Kalisch, 2004).

Kalisch and Kalisch concluded that part of the problem with 21st century nursing is that nursing is still a single-sex, woman-dominated profession (93% female), and gender barriers to access for most of the other professions has systematically come down, thus, providing more options for women. Women now constitute about 50% of admissions to medical, dental, veterinary medicine, and law schools, and dominate admission to pharmacy programs. Also, the image of nursing continues to be dominated by a few ancient stereotypes associated with following doctors' orders, taking temperatures, giving medication, and doing a significant amount of housekeeping work.

Military Influences

In April 1917, the United States entered into World War I. In order to train large numbers of skilled nurses to fill the needs brought on by the war, the Committee on Nursing instituted the Army School of Nursing and the Vassar Training Camp, in addition to the Student Nurse Reserve. The Army School of Nursing was developed as a training program for nurses that featured academics and direct training in army hospitals. According to Schorr (1999) the Vassar Camp, which included academic preparation on college grounds and training in cooperating hospital schools of nursing, paved the way for incorporating nursing education into institutions of higher learning (Schorr 1999)

During World War I, Army and Navy nurses cared for soldiers with more devastating wounds than they had ever seen. The soldiers' injuries came from bullets, shrapnel, shells, chlorine, and mustard gas. Donahue (1996) reported that American nurses on active duty faced not only the horrors and dangers of war but other types of conflicts and frustrations as well. These arose primarily because the nurses had no military rank. Army and Navy nurses had not been designated by Congress as either officers or enlisted personnel, although they had military status and were subject to military discipline. Nurses could not assume the responsibilities for teaching and directing orderlies and corpsmen. They were not allowed to handle administrative problems as managers of wards and nursing services. Following the war, with the help of legal and other advisers and the support of the Votes for Women Amendment, nurses appealed to Congress. On June 4, 1920, the National Defense Act granted members of the Army Nurse Corps relative rank. This allowed nurses to be given officer status ranging from second lieutenant through major (Donahue, 1996).

On December 7, 1941, the Japanese bombed the U.S. Navy base at Pearl Harbor. On December 8, the United States and Great Britain declared war on Japan, and on December 11, Germany and Italy declared war on the United States. During World War II, 292,131 Americans were killed and almost 670,000 were injured. Throughout this time, nurses were called upon in mass numbers to serve their country (Schorr, 1999). During World War II, there was a great demand for nurses on the battlefields and at home. Because many nurses volunteered to serve during the war, several civilian hospitals lost nursing personnel.

In 1943 Congress passed the Nurse Training Act. An appropriation of sixty million dollars was voted at this time to cover the cost of an accelerated and expanded program of education for students entering approved schools of nursing, and later the amount was increased. The bill, commonly known as the Bolton Act, created the United States Cadet Nurse Corps. Under the Bolton Act, the entire education of nursing students was subsidized. It provided a thirty-month basic program, free tuition and fees, free uniforms, monthly stipends for students in approved basic schools of nursing, and grants for postgraduate work (Donahue, 1996).

After completion of the thirty-month nursing education program, women were obligated to engage in essential military or civilian nursing for the duration of the war. Candidates were to be between the ages of 17 and 35 and fulfill minimum admission requirements, which included good health and graduation, with a good scholastic record, from an accredited high school (Kalisch & Kalisch, 2004).

Schrefer (2000, p. 60 and 61) included a letter that was written by a student nurse dated February 22, 1945:

> The first 6 months of this program is known as the Probation Period, and we are known as probies. Right now I am feeling low. I am not certain if I entered a convent, joined the army, was sent to jail, or a combination of all three! From the first day, we wore the full uniform from morning to night. The collars are so stiff they rubbed my neck raw, and I have line, like a scar, on both sides of my neck that will be noticeable when I get a tan this summer. Right now we wear the blue checked dress with the collar and cuffs. When we get our caps, we will also begin wearing the bib, and then we will really be dressed up. I suppose we are lucky; we are the first class to wear white hose; the previous classes had to wear terrible black cotton hose during the probation period.
>
> We have classes from 7 in the morning to 4:30 in the afternoon Monday through Friday. We have 30-minute lunch and 10 minutes between classes. At night, we have compulsory study hours from 8 to 10. Ms. Dawkins, the housemother, makes frequent rounds to make sure everyone is in their room and at their desks. A typical day looks something like this:
>
> 5:00 am Get up
>
> 5:30 am Breakfast
>
> 6:00 am Go to Chapel
>
> 7:00 am Class in Nursing Arts Lab
>
> 12:00 pm Lunch
>
> 12:30 pm To dorm for smoke, bathroom
>
> 2:00 pm Chemistry lab
>
> 3:00 Anatomy and Physiology class
>
> 4:00 Anatomy and Physiology lab
>
> 5:45 Dinner
>
> 6:00 – 8:00 Free time in dormitory
>
> 8:00 – 10:00 Study period
>
> 10:30 Lights out
>
> On Saturday we have "housekeeping" duties from 7 in the morning to noon. We are assigned a partner and given assignments to wash and scrub the Chemistry lab and the Diet Therapy lab, dust the books in the library, and dust and polish the faculty offices.
>
> Our classes are Anatomy and Physiology, Chemistry, Microbiology, and Nursing Arts. We have to be in our seat, books open, and not talking when the instructor enters the room. We stand and wait until she reaches the front of the room and tells us to be seated. We spend every morning from 7

> to noon in the Nursing Arts lab. We began with the very basic nursing procedures, the bed bath, taking temperature, pulse, and respirations, making beds, etc. The reason this class takes so much time is that they are preparing us to go on the "floor." In the first class we were told that on the floor or in the classroom we were always to address each other as Miss______, and never by our first names. (Schrefer, 2000, p. 60 and 61).

During World War II, Washington began to understand how vital nurses were to the war effort. According to Kalisch and Kalisch (2004), on December 19, 1944, newspapers across the nation carried an article by columnist Walter Lippmann, who charged the army with gross neglect of wounded soldiers by not having provided an adequate number of nurses to care for them. In his State of Union message on January 6, 1945, President Roosevelt told the nation that he would request a draft of women nurses. Because nurses were not volunteering in sufficient numbers, some congressmen supported the president's proposal for the draft as the only practical solution to the problem. The request quickly passed the House of Representatives; however, became bogged down in the Senate. Due to the threat of the draft, nurses responded by quickly volunteering for military service.

Ten thousand applications were filed between January 8 and January 29, 1945. Kalisch and Kalisch (2004) added that when Colonel Florence A. Blanchfield, superintendent of the Army Nurse Corps returned from Europe, she found that there were actually too many nurses. By April 1945, 54,000 graduate nurses had not been assigned, and the number of senior cadet nurses in military hospitals had more than doubled, to a total of 6000. Due to the overabundance, Colonel Blanchfield recommended that 2000 civilian nurses be released from their military commitment. After this recommendation, Congress ceased efforts to pass the proposed draft legislation (Kalisch & Kalisch, 2004).

The Cadet Nurse Corps was terminated in 1948. During the five years of the Cadet Nurse Corps, it had received over $160 million in federal appropriations and had graduated 125,000 students. In addition, approximately 15,000 graduate nurses had received federal funds for advanced study before the grants were discontinued on October 15, 1945. Kalisch and Kalisch (2004) included that as a result of the Cadet Nurse Corps, hospital-nursing schools obtained better-qualified instructors and head nurses.

Men in Nursing

Since 1901, male nurses had been barred from the Army Nurse Corps, because the law that had brought it into being designated it as the "Army Nurse Corps, Female" (Kalisch and Kalisch, 2004, p. 375) This fact was brought to the attention of the ANA board of directors in January 1941 by the Men Nurses' Section of the ANA, which sought repeal of this law and enactment of a law to give "men and women nurses equal opportunities in the military service" (Kalisch and Kalisch, 2004, p. 375). In May 1942, the following resolution was adopted at a meeting of the ANA House of Delegates:

> Whereas, the Army and Navy are in great need of the services of graduate, registered professional nurses; and whereas, the graduate, registered professional men nurses, members of the American Nurses' Association, are prepared to render this service; therefore, be it resolved: that the American Nurses' Association in convention assembled in Chicago, May 17-22, 1942, address a communication to the Surgeons General of the Army and of the Navy, respectfully requesting that graduate, registered professional men nurses, members of the American Nurses' Association, be given the opportunity to serve as nurses as soon as possible after induction or enlistment into the armed forces of the country (Kalisch & Kalisch, 2004, p. 375).

Kalisch and Kalisch further stated male nurses who were employed in military service had no official status. They received no recognition as a professional group, no authority, and no distinctive marking to identify them to the wounded or to other health workers. Reports from male nurses in the army showed that their services as nurses were not used. Others revealed that although they were serving as nurses, they were doing it without nursing rank.

A 1946 survey showed that 27 states had a total of 68 nursing schools that admitted men, but that 13 states had only one school each. New York topped the list with 22 schools. Eighteen of them were in state mental hospitals, which admitted men and women. From 1938 to 1946, 24 of the reporting schools admitted 853 men, of whom 633 went on to graduate. Lack of appropriate housing facilities was the primary obstacle to the admission of men to more schools (Kalisch & Kalisch, 2004).

According to Kalisch and Kalisch (2004), existing barriers to the employment of male nurses appeared to be due more to sentiment and tradition than to any actual ineptitude based on gender. Kalisch and Kalisch further added that male nurses would have a difficult road ahead in the coming decades, and the battle against feminine stereotyping of nurses would never really get off the ground until a massive effort could be launched at resocializing the general public.

Professionalization

In 1948, Esther Lucille Brown, Ph.D., of the research staff of the Russell Sage Foundation recommended changes in nursing and nursing education. The report was entitled, *Nursing for the Future* and stated, “Today the nurse probably ranks close to the teacher as a social necessity” (Kalisch and Kalisch, 2004, p. 334). Brown further stated tax dollars did not assist nursing education as it did teacher training, and other conditions within and outside the profession had alarmingly reduced the number of applicants available for training. Nursing was fighting a losing battle in attracting the needed numbers of young women (Kalisch & Kalisch, 2004).

Brown’s report stated conditions in nursing education were regarded as central to the whole problem of the profession. “By no stretch of the imagination can the education provided in the vast majority of some 1,250 schools be conceived of as professional education” (Kalisch and Kalisch, 2004, p. 335). Brown perceived that many hundreds of hospitals still operated schools to avail themselves of the services of student nurses. She recommended efforts be directed at building basic schools of nursing in universities and colleges, comparable in number to existing medical schools. Brown’s report recommended the following: (Kalisch and Kalisch, 2004, p. 335).

That nursing makes one of its first matters of important business the long overdue official examination of every school. That lists of accredited schools be published and distributed, with a statement to the effect that any school not named had failed to meet minimum requirements for accreditation or had refused to permit examination.

That a nationwide educational campaign be conducted for the purpose of rallying broad public support for accredited schools and for subjecting slow-moving state boards and nonaccredited schools to strong social pressure. That provision is made for periodic re-examination of all schools listed or others requesting it, as well as for first examination of new schools, and for publication and distribution of the revised list. That, if organized nursing committed itself to this understanding of major social significance, the public assumes responsibility for a substantial part of the financial burden.

Kalisch and Kalisch (2004) concluded after the Brown report, nursing education was slowly becoming a well-planned program of preparation for a calling that could rank as the equal of other professions. In making this transition, nursing education was moving into colleges and universities. Kalisch and Kalisch revealed that nursing was finding in colleges the proper intellectual climate for the preparation of the professional worker. Nurse educators with vision were strongly impressed with the need for better teaching and for better resources in libraries, laboratories, and other physical facilities for education available in colleges and universities. They were beginning to realize the need for developing research in nursing and for professional writing and publication if nursing were to bring abreast its associated professions.

Despite controversy, nursing organizations began to establish accreditation programs, through the Committee to Implement the Brown Report, soon renamed the National Committee for the Improvement of Nursing Services. It was recognized that some classification method was necessary to focus attention on the need for more rapid improvement in basic nursing programs. Accordingly, the Subcommittee on School Data Analysis was appointed to study all nursing schools in the United States. Although participation was voluntary, 96% of the schools returned the subcommittee questionnaire (Kalisch & Kalisch, 2004).

Statistical procedures were used to analyze information submitted on the questionnaires, and each school was evaluated in terms of long-accepted criteria by the profession. Schools were classified according to their total score on a 100-point scale based on standards of nursing recommended by the professional organizations. Examples of the weight given to various criteria include; administrative policies 3 points; faculty 22 points; curriculum 16 points; and student performance on state board examinations 15 points.

Kalisch and Kalisch (2004) included that when ranked according to general, overall excellence, schools in the upper 25% were classified as Group I, those in the middle 50% as Group II, and those in the lowest 25% as Group III. The schools reporting to the subcommittee (1150 of 1190 state accredited schools) were classified as follows; Group I: 301 schools; Group II: 567 schools; and Group III: 282 schools

Nursing in North Carolina

According to Newell (1996), Moravians in Bethabara and Salem North Carolina were providing the earliest planned care of the sick by setting up “sick rooms,” and assigning the brethren and sisters as “sick nurses.” Newell further added that Salem, North Carolina had a remarkable modern health department by 1772 that included a doctor, midwife, and nurses instructed by a doctor.

As the Civil War began in 1861, North Carolina had neither hospitals nor trained nurses. Many southern women volunteered their services as nurses due to the shocking number of casualties. Florence Nightingale’s “Notes on Nursing” was their only instruction manual. Prior to the Civil War, most American women had been restricted to domestic duties. However, by the end of the Civil War, women had established fifteen military hospitals in North Carolina, and helped create the new career of professional nursing (Wilson & Lifler, 2002).

In 1876, St. Peter’s Hospital in Charlotte became the first civilian hospital in the state of North Carolina, and in 1891, the Good Samaritan Hospital opened in Charlotte as the first privately funded, independent hospital in North Carolina dedicated for the treatment of African Americans. After this time, hospitals began to spring up across North Carolina, and the need for educated nurses became apparent. In 1894, North Carolina’s first nursing school opened at Rex Hospital in Raleigh. Mary Lewis Wyche, a Vance County native and nursing graduate of Philadelphia General Hospital, started the school shortly after becoming head nurse at Rex Hospital. Watts Hospital School of Nursing opened in Durham in 1895, and is the oldest school of nursing still in operation in the state of North Carolina. In 1896, St. Agnes School of Nursing in Raleigh became the first professional

nursing school for African-Americans in North Carolina. Additional schools of nursing for African-Americans opened in 1902 at Charlotte's Good Samaritan Hospital, and at Lincoln Hospital in Durham (Wilson & Lefler, 2002).

Although North Carolina had several training schools for nursing, there were no professional standards and no registration of nurses. In 1902, Mary Lewis Wyche organized and became the first president of the North Carolina Nurses Association, which framed a bill to provide for the registration of educated nurses. On March 3, 1903, North Carolina became the first state in the nation to pass a nurse registration law. New York and Virginia followed North Carolina later that year. By 1923, all 48 states had legislation regulating nursing (Wilson & Lefler, 2002).

In 1917, North Carolina passed a law establishing a training school inspector appointed by the North Carolina Nurses Association. The next year, the North Carolina League of Nursing Education was formed as a section of the North Carolina Nurses Association. The next two decades saw an increased interest in nursing education, with more carefully planned curricula, higher entrance requirements, and better classrooms and instructors (UNC-TV, 1994-2003).

In 1923, Carrie Early Broadfoot of Fayetteville organized a professional association for African-American nurses. In 1948, the North Carolina Nurses Association voted to open its membership to all registered nurses in North Carolina, and the "Colored Nurses Association" voted itself out of existence. In 1928, North Carolina adopted the Model County Midwife Regulations, requiring that all midwives receive instruction from doctors or nurses in order to receive a permit to practice (UNC-TV, 1994-2003).

During World War I, there were 111 North Carolina Red Cross nurses in military service (Newell, 1996). In 1943, due to World War II, the demand for nurses increased. A federally funded nursing training program was started called the U.S. Cadet Nurse Corps. By 1945, over 1,000 nurses from North Carolina were serving in the Armed Forces (Wilson & Lefler, 2002).

After World War II, the nursing shortage continued, and the North Carolina Nurse Practice Act included regulations for Licensed Practical Nurses. Though diploma programs were educating the majority of North Carolina's nurses, the need for nursing education to occur in colleges and universities was brought to the table. North Carolina nursing leaders stated that little "new" knowledge was gained in the diploma programs. In the diploma nursing programs, a student would train in the hospital, work in the hospital, and then teach in that hospital (Wilson & Lefler, 2002).

In 1931, Duke University began a three-year nursing diploma program. Nursing students at Duke could receive a baccalaureate degree with two additional years at Duke University. In 1950, the University of North Carolina at Chapel Hill became the first nursing program in the state to offer a four-year baccalaureate-nursing program, and in 1964, North Carolina's community colleges began offering a two-year associate degree-nursing program. Today, 57 of North Carolina's 58 community colleges offer three-semester programs to prepare licensed practical nurses and/or five-semester associate degree programs to prepare registered nurses (UNC-TV, 1994-2003; Wilson & Lefler, 2002).

The late 1960s to the mid 1970s saw the implementation of nurse practitioners in the state of North Carolina. In 1969, Dr. Lucy Conant, dean of the UNC School of Nursing, worked with Medical School Dean Isaac Taylor and the Department of Public Health Nursing Chair Margaret Dolan to develop one of the first nurse practitioner programs in the nation. In 1975, North Carolina passed a legislation that allowed licensed nurses to

perform medical acts and prescribe medications. By 1976, there were 90 nurse practitioners, and in 2003, approximately 2,000 nurses worked as nurse practitioners in the state of North Carolina (UNC-TV, 1994-2003).

One of the nation's first Area Health Education Centers (AHECs) was started in North Carolina in 1972. Presently, AHEC offers nurses throughout North Carolina access to RN to BSN and Master in Nursing outreach programs, as well as a wide variety of continuing education opportunities through the state's nursing schools. In 1981, there was a major development in the self-regulation of North Carolina nursing. North Carolina became the only state in the nation to allow nurses to elect nurse members to the Board of Nursing rather than having them appointed by the Governor. The North Carolina Board of Nursing is made up of nine RNs, four LPNs, and the Governor (UNC-TV, 1994-2003).

In 1983, Certified Nurse Midwives received recognition to practice in North Carolina. During the 1980s, there were around 40 practicing midwives. In 1991, East Carolina University opened the first nurse midwifery educational program, and in 2001, there were nearly 200 certified nurse midwives in the state of North Carolina. In 1989, the UNC School of Nursing established a PhD program in Nursing, and in 2002, the second doctoral nursing program opened at East Carolina University School of Nursing (UNC-TV, 1994-2003).

Due to the severe nursing shortage in 1991, the North Carolina Nurses Association (NCNA) created the NC Center for Nursing. The NC Center for Nursing is the first state-funded agency in the nation dedicated to assuring adequate nursing resources for its citizens. In 1999, North Carolina became the sixth state to join in the multi-state compact, which allows registered nurses and licensed practical nurses to practice in compact states. By 2002, eighteen states have signed on the multi-state compact. In 2002, the North Carolina Nurses Association and the North Carolina Board of Nursing celebrated the 100th anniversary of the signing of the Nurse Practice Act that occurred on March 3, 1903. During this celebration, Mary Lewis Wyche, founder of the North Carolina Nurses Association was named to the ANA Hall of Fame (UNC-TV, 1994-2003).

Summary

Educated and uneducated nurses have been providing care to the ill and injured since the beginning of time. Many of the problems nurses face today, such as nursing shortages, have been an on going problem since the early 1900s. Historical literature has shown that the nursing profession has undergone many trials, and has endured many changes. Nurses have been there throughout the century, responding to the needs of the nation. Nurses have followed troops around the world during times of war, climbed on horseback to meet the needs of rural families, and delivered babies in homes. Through the efforts of women like Florence Nightingale and Mary Lewis Wyche, nurses are highly educated professionals.

This chapter has provided a compilation of the historical literature pertaining to the history of nursing and nursing education prior to Florence Nightingale, the Nightingale Revolution, and data on the history of nursing in the United States, and North Carolina. Chapter 3, which follows, outlines the research design of this study, which is to continue with the documentation of nursing education history at Park View Hospital.

III. Research Methods

In March of 2003,North Carolinacelebrated the first century of professional nursing. Nurses have gone from receiving nonstructured nursing education based on hospital experience, to attending formal institutions of learning based on curricula developed by educated health care professionals. Presently, there is very little organized data on the history ofParkViewHospitalor Park View School of Nursing. There is no document that truly captures the historical contribution that Park View School of Nursing has made to the field of nursing. Therefore, the purpose of this research is to examine the history of nursing education in terms of one hospital inNorth Carolina. This chapter describes the research methodology and design used to examine these issues.

Qualitative Research

Reconstruction of the past from a critical review of documents, artifacts, and individuals is a qualitative method of research. Qualitative research is a loosely defined category of research designs or models, all of which elicit verbal, tactile, olfactory, and gustatory data in the form of descriptive narratives like field notes, recordings, or other transcription from audio and videotapes and other written records, pictures, or films (Preissle, n.d.). Therefore, using qualitative research to analyze historical evidence may provide more insight into understanding the history of nursing and nursing education.

Merriam (1998) stated qualitative research can reveal how all the parts work together to form a whole. It is assumed that meaning is embedded in people's experiences and that this meaning is mediated through the investigator's own perceptions. Thus, by utilizing types of qualitative data collection such as oral interviews and documents, one may better understand nursing experiences that make up the history of nursing and nursing education.

Characteristics of Qualitative Research

Merriam (1998) described the characteristics of qualitative research by stating qualitative research implies a direct concern with experience as it is "lived"- or "felt" or "undergone." According toDavis(1997), the informant is allowed to tell their own stories and to stay close to immediate experience rather than interpretation or abstraction. These characteristics are important when performing historical nursing research through oral interviews. Using oral interviews from nurses and physicians who have experienced or "lived" during the time of the research topic can assist the researcher in identifying data that has been submerged in the past.

According to Merriam (1998), the researcher is the primary instrument for data collection. Davis(1998) added that a close rapport and trust should develop between the researcher and the informant. This serves research in the area of historical nursing data well because research participants (nurses and physicians) will be more willing to provide information from their past if they feel comfortable and trust the researcher. Also, nurses and physicians should be made to feel proud of their experiences.

Qualitative research focuses on process, meaning, and understanding. The product of a qualitative study is richly descriptive. Words and pictures rather than numbers are used to convey what the researcher has learned about a phenomenon (Merriam, 1998). This is appropriate for historical data collection because words from interviews obtained during oral interviews, and information from historical archives are vital to assisting the researcher learn about the history of nursing and nursing education.

Preissle (n.d.), informed us of the strengths of qualitative research. She stated qualitative research provides more detail and depth. The researcher may not get as much depth in a standardized questionnaire. Preissle further added that qualitative research is open and it can generate new theories and recognize phenomena ignored by most or all previous researchers and literature. Again, this is another key aspect for the

historical researcher to consider. As stated in Chapter One, knowledge of nursing history can provide insight into problems of today, such as the present nursing shortage. Through researching the interventions that nurses implemented to combat previous nursing shortages in the 20th century, nurses may learn valuable lessons for addressing the present nursing shortages in the 21st century.

Rationale for Use of Historiography

The particular qualitative strategy used in this study was historiography. Historiography is the method of doing historical research or gathering and analyzing historical evidence. Johnson and Christensen (n.d.) stated historiography is not a mere accumulation of facts and dates or even a description of past events. It is a flowing, dynamic account of past events, which involves an interpretation of these events in an attempt to recapture personalities, and ideas that influenced these events.

One of the goals of historical research is to communicate an understanding of past events (Johnson & Christensen, n.d.). Some aspect of the past is studied by perusing documents of the periods, by examining relics, or by interviewing individuals who lived during the time. An attempt is then made to reconstruct what happened during that time as completely and as accurately as possible (Fraenkel & Wallen, 2000).

According to Fraenekel and Wallen (2000), there are four essential steps involved in doing a historical study in education. These include: (a) defining the problem or question to be investigated; (b) locating relevant sources of historical information; (c) summarizing and evaluating the information obtained from theses sources: and (d) presenting and interpreting this information as it relates to the problem or question that originated the study.

Sources of historical data are classified as either primary or secondary. Primary sources include the oral testimony of eyewitnesses, documents, records, and relics. Secondary sources include the reports of persons who relate the accounts of actual eyewitnesses and summaries, as in history books and encyclopedias (Marshall & Rossman, 1995). The primary sources utilized in this study were oral interviews with previousParkViewHospitalnursing graduates and a former Park View physician, investigating Park View School of Nursing annuals and school records, and reviewing newspaper articles aboutParkViewHospitalandSchoolofNursing. Secondary methods used in this study were reading various history books pertaining to nursing history and viewing a video pertaining to the history of nursing inNorth Carolina.

According to Marshall and Rossman (1995), historiography is particularly useful in obtaining knowledge of previously unexamined areas and in reexamining questions for which answers are not definite as desired. This idea was considered because presently there is very little organized data on the history ofParkViewHospitalor Park View School of Nursing.

The lack of formal knowledge about the subject may impede the research because historians bring their own points of view to their arguments about the past. Without some familiarity with the topic, one has difficulty reading their texts in a meaningful way. One may ask friends, colleagues, and historians for help in locating an expert who can compile a reading list (Denzin & Lincoln, 1994). In this study, the researcher had taught nursing history for eight years. The researcher also consulted with a Park View School of Nursing historian regarding the appropriate Park View graduates to interview.

Sheeley (n.d.) concluded by stating historiography leads to identification of research problems to the formulation of conclusions. Much of what happened in the past remains submerged, even with the best historical

inquiry. However, having a better understanding of persons, places, things, and events in the helping professions can contribute to the future quality of personal and professional lives.

Data Collection and Analysis

Data collection is a series of interrelated activities aimed at gathering information to answer research questions (Creswell, 1998). The methods used for gathering data for this qualitative historical research is in the form of observation, in-depth interviewing, review of documents, and videos.

Data analysis is the process of making sense out of the data. Making sense out of data involves consolidating, reducing, and interpreting what people have said and what the researcher has seen and read, it is the process of making meaning (Merriam, 1998). Qualitative data analysis is a search for general statements about relationships among categories of data; it builds grounded theory (Marshall & Rossman, 1995). In this study, information came from data collected from observations made at the Park View School of Nursing Anniversary Dinner; in-depth interviews from former Park View School of Nursing graduates and former Park View Physicians; reviewing historical documents; and from a nursing history video.

Fraenkel and Wallen (2000) stated the process of reviewing and extracting data from historical sources included determining the relevance of the particular material to the question or problem being investigated; recording the full bibliographic data of the source; organizing the data one collects under categories related to the problem being studied; and summarizing pertinent information on note cards.

The challenge associated with data analysis according toMarshalland Rossman (1995) is that it is messy, ambiguous, and time-consuming. It does not proceed in a linear fashion; it is not neat. Data from this research was analyzed to produce organized information on the history of nursing and the history of nursing education at Park View hospital.

Observation

Observation entails the systematic noting and recording of events, behaviors, and artifacts in the social setting chosen for the study (Marshall & Rossman 1995). The observation component of this research took place on May 26, 2001. On this date, graduates and physicians from Park View School of Nursing held their 87th anniversary banquet. Due to my interest in researching Park View School of Nursing history, I attended the dinner.

Marshall and Rossman (1995) stated the researcher makes no special effort to have a particular role; to be tolerated as an unobtrusive observer is often enough. In the early stages of qualitative inquiry, the researcher typically enters the setting with broad areas of interest but without predetermined categories or strict observational checklists. At the beginning of the banquet I mingled among the former graduates in order to get to know them. At this time I had not set an agenda or schedule nor did I tell the former graduates my purpose for attending the banquet. I had the opportunity to just sit back and listen to their stories about their days as student nurses at Park View. Through listening to these stories, I was able to get a mental picture of what it must have been like to be a Park View nursing student in the 1930s, 1940s, and beyond. Also, by mingling and being a bystander, I was allowed the opportunity to observe which nurses I thought would be best for the oral interviews.

During the banquet dinner, I had the opportunity to sit with several former Park View School of Nursing graduates. Again, I had the chance to hear Park View history directly from former graduates. After the dinner, a former Park View School of Nursing graduate was the keynote speaker. During her speech she provided a power-point presentation of various pictures that had been scanned from old Park View School of Nursing annuals and from newspapers. Through observing the power-point presentation, I was able to get an idea of what I should focus on during my research.

After the keynote speaker was finished, the former Park View School of Nursing graduate that had invited me to the dinner began to tell some of the former graduates the purpose of my research. It is during this time that I met several nursing graduates from 1936 to 1969 who stated they would be interested in participating in my research.

According to Marshall and Rossman (1995), the value of the researcher entering the research setting with broad areas of interest without predetermined categories or strict observational checklist is the researcher is able to discover the recurring patterns of behavior and relationships. After such patterns are identified and described through early analysis of field notes, checklists become more appropriate and context-sensitive.

To begin my research of the nurses from the anniversary banquet, I met with a colleague who is a 1968 Park View School of Nursing graduate. She and I reviewed the graduates' names from the Park View reunion dinner guest book and decided which graduates would be most qualified for the oral interviews. According to the reunion guest book, there were 93 Park View School of Nursing graduates attending the dinner. During our assessment process, we also reviewed some notes I had taken from the anniversary banquet. This 1968 graduate remains in contact with several of the former graduates; therefore, she is aware of nurses that graduated during specific decades and is mindful of their probable willingness to discuss their experiences at Park View School of Nursing. Also, due to the advance age of many of the graduates, another consideration in determining interview candidates is the health problems of some of the graduates. The 1968 graduate was aware of these factors and helped me decide which graduates were capable of participating in the interview process.

In-Depth Interviewing

Qualitative in-depth interviews are much more like conversations than formal events with predetermined response categories. The researcher explores a few general topics to help uncover the participant's meaning perspective, but otherwise respects how the participant frames and structures the responses (Marshall & Rossman, 1995).

Prior to beginning the oral interviews, an application was made to the Institutional Review Board (IRB) atEastCarolinaUniversity. According to Marshall and Rossman (1995), a degree of systematization in questioning may be necessary. Therefore, included in the IRB application was the list of questions that would be asked during the oral interviews. These questions include: See Appendix A.

Interviews have particular strengths. An interview is a useful way to get large amounts of data quickly. When more than one person participates, the interview process gathers a wide variety of information across a larger number of subjects rather than if there were fewer participants (Marshall and Rossman, 1995). During the interview process, graduates from 1939, 1945, 1957, and 1968 were interviewed. A Park View graduate from 1938 who was also a nursing supervisor, a 1958 Park View School of Nursing graduate who later became a Park View nursing instructor, and a physician who practiced at Park View Hospital and taught the Park View nursing students was also interviewed. Marshall and Rossman (1995) stated interviewers should have superb listening

skills and be skillful at personal interaction, question framing, and gentle probing for elaboration. During the interviews, the participants were noted to be eager to share their personal nursing history and appeared to be relaxed during the interview process. Marshall and Rossman concluded by stating combined with observation; interviews allow the researcher to understand the meanings people hold for their everyday activities.

After receiving IRB approval and after selecting the Park View nursing graduates for the oral interviews, each selected graduate was called and asked if they would be interested in participating in the research. During the telephone conversation, it was explained that 13 interview questions would be asked. The most important aspect of the interviewer's approach concerns conveying an attitude of acceptance…..that the participant's information is valuable and useful (Marshall and Rossman, 1995). Therefore, during the initial telephone conversation it was explained that they would be asked to share other information they believed would be interesting and beneficial to the research. Last, each former Park View Nursing School graduate was told they would be asked to sign an informed consent and with their permission, the interview would be audio taped.

The Review of Documents

Documents are written or printed materials that have been produced in some form or another-annual reports, books, circulars, court records, diaries, newspapers, magazines, school yearbooks, and so on. Documents refer to any kind of information that exists in some type of written or printed form (Fraenkel and Wallen, 2000). While attending the Park View School of Nursing reunion banquet, I met the historian for Park View. Over the years she had collected numerous newspaper articles pertaining to Park View Hospital and Park View School of Nursing. In addition to newspaper articles, she also collected Park View school yearbooks. After explaining the purpose of the research, I was granted permission to use these newspaper articles and yearbooks for the research. The other historical source used for this research was nursing history books.

Marshall and Rossman (1995) stated the use of documents often entails a specialized approach called *content analysis.* Fraenkel and Wallen (2000) included that content analysis is a methodology that is often used in conjunction with other methods, in particular historical research. Content analysis is described by Marshall and Rossman as an overall approach, a method, and an analytic strategy. Content analysis entails the systematic examination of forms of communication to document patterns objectively. Traditional content analysis allows the researcher to obtain an "objective and quantitative description" (Marshall and Rossman, 1995, p.85) of the content of various forms of communication, usually written materials (textbooks, novels, newspapers).

During the content analysis for this research, newspaper articles pertaining to Park View Hospital or Park View School of Nursing were first categorized according to their date of publication. The articles were then researched for their content relating to nursing history and nursing education at Park View School of Nursing. After the articles pertaining to nursing history and nursing education at Park View were read, it was then decided which content from the articles was most relevant for the research. Marshall and Rossman (1995) stated the greatest strengths of the content analysis method are that it is unobtrusive and nonreactive. It can be conducted without disturbing the setting in any way. The researcher determines where the greatest emphasis lies after the data have been gathered.

Documents may be the only means of studying certain problems. One area where documents are crucial to an investigation is historical studies, in which events can no longer be observed and information may not recall or be available for recall (Merriam, 1988). Numerous Park View School of Nursing graduates are still alive with intact memories of their days as student nurses and as staff nurses at Park View. However, the data pertaining to the history of nursing and nursing education in the United States and North Carolina dated back before the year 500 A.D.; therefore, nursing history documents were utilized.

Video

Films can capture the daily life of the group under study. Films provide visual records of passing natural events and may be used as permanent resources. Research filming is a powerful tool for inquiry into past events. Film is particularly valuable for discovery and validation. It documents nonverbal behavior and communication, such as facial expressions and emotions. Film preserves activity and change in original form. Film allows for the preservation of rare events (Marshall & Rossman, 1995).

For this research, the video entitled, "North Carolina Nurses: A Century of Caring" was used. The video explores the vital roles of the North Carolina Nurses Association and the North Carolina Board of Nursing in standardizing nursing education, expanding nursing practice, and dealing with critical nursing shortages. The video uses a combination of archival film and photographs, contemporary footage, and on-camera interviews.

Validity

Validity is the degree to which correct inferences can be made based on results from an instrument. It depends not only on the instrument itself, but also on the instrumentation process and the characteristics of the group studied (Fraenkel & Wallen, 2000). Qualitative researchers aim for a deep understanding that comes from personally talking with study participants and probing to obtain detailed meaning (Creswell, 1998).

To objectively evaluate the data, both internal and external criteria are applied to establish the validity, credibility, and usefulness of source materials. The application of external criteria helps establish validity, for example, if the source of information is not authentic, it cannot be used. The qualitative constructs that were utilized to establish validity in this study were credibility, transferability, dependability, and confirmability (Qualitative Validity. (n.d). Retrieved November 17, 2003. from http://www.trochim.human.cornell.edu/kb/qualval.htm.

Credibility

The goal of credibility is to demonstrate that the inquiry was conducted in such a manner as to ensure that the subject was accurately identified and described (Marshall & Rossman, 1995). The researcher should demonstrate that the results and conclusions are credible from the perspective of the research participants. The purpose of qualitative research is to describe or understand the phenomena of interest from the participants' eyes; the participants are the only ones who can legitimately judge the credibility of the results (Qualitative Validity. (n.d). Retrieved November 17, 2003. from http://www.trochim.human.cornell.edu/kb/qualval.htm). Patton suggested credibility is obtained by member checks, peer evaluation, and examining the data from multiple perspectives (1990).

Peer evaluation and member checks involve others in the research. Member checks refer to allowing the participants to review the findings and confirm that the findings concur with their feelings and attitudes. Member checks are critical for establishing credibility because they allow the participants to verify the data, correct mistakes, and clarify misunderstandings (Guba & Lincoln, 1988). During the research process, various Park View School of Nursing graduates were ask to review the findings to make certain the information was correct, and that it reflected their feelings of Park View School of Nursing.

Peer evaluation provided the researcher with review at various stages of the research. Peer evaluation gives the researcher the opportunity to defend and clarify the study (Creswell, 1998). While conducting and writing the research, different nursing colleagues from Edgecombe Community College reviewed the information.

Transferability

Transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings. The qualitative researcher can enhance transferability by doing a thorough job of describing the research context and the assumptions that were central to the research. The person who wishes to "transfer" the results to a different context is then responsible for making the judgment of how sensible the transfer is (Qualitative Validity. (n.d). Retrieved November 17, 2003. from.trochim.human.cornell.edu/kb/qualval.htm.)

Historical research can be examined from many different perspectives; therefore, it was expected that this research could lay the foundation for the development of other studies of Park View School of Nursing, or other nursing programs or other professional training institutions.

Dependability

According to Marshall and Rossman (1995), dependability is defined as the researcher attempting to account for changing conditions in the phenomenon chosen for the study as well as changes in the design created by increasingly refined understanding of the setting.

Confirmability

Confirmability refers to the degree to which the results could be confirmed or corroborated by others (Marshall & Rossman, 1995). Throughout this research, numerous nursing history books were utilized to assess for similarity in data. The Park View School of Nursing graduates were ask to review the information obtained during the oral interviews and from newspaper articles to confirm if the data was correct.

Limitations

There were several limitations associated with this research. Once these areas were identified, attempts were made to decrease the consequences of these limitations. The limitations identified in this research were authenticity and accuracy of historical documents, limitations and weaknesses of interviews, the age of the interview participants, and the weaknesses and limitations of film.

Authenticity and Accuracy of Historical Documents

Historical analysis cannot use a direct observation approach and there is no way to test a historical hypothesis. There are also weaknesses in the classification of historical data. Documents may be falsified deliberately or may have been subject to incorrect interpretations on the part of the recorder. Words and phrases used in old records may now have different meanings (Marshall & Rossman, 1995).

According to Merriam (1998), a problem with documentary materials is determining their authenticity and accuracy. She states determining the authenticity and accuracy of documents is part of the research process,

and that documents should not be used in isolation. It is the investigator's responsibility to determine as much as possible about the document, its origins and reasons for being written, its author, and the context in which it was written.

Throughout this research, the researcher not only used written documents, but also incorporated oral interviews, observation, and video into the methodology. In order to assess authenticity, the researcher considered questions provided by Merriam (1988, p.122). She suggested using these questions when reviewing the authenticity of documents. Merriam also stated that these questions apply to historical documents. These questions include:

- What is the history of the document?
- How did it come into my hands?
- What guarantee is there that it is what it pretends to be?
- Is the document complete, as originally constructed?
- Has it been tampered with or edited?
- If the document is genuine, under what circumstances and for what purposes was it produced?
- Who was/is the author?
- What was he/she trying to accomplish? For whom was the document intended?
- What were the maker's sources of information? Does the document represent any eyewitness account, a secondhand account, and a reconstruction of an event long prior to writing, an interpretation?
- What was or is the maker's bias?
- To what extent was the writer likely to want to tell the truth?
- Do other documents exist that might shed additional light on the same story, event, project, program, context? If so, are they available, accessible? Who holds them?

Limitations and Weaknesses of Interviews

Interviewing has limitations and weaknesses. Interviewees may be unwilling or uncomfortable sharing all that the interviewer hopes to explore, or they may be unaware of recurring patterns in their lives. The interviewer may not ask questions that evoke long narratives from participants either because of lack of expertise or familiarity with the subject. The interviewer may not properly comprehend responses to the questions or elements of the conversation (Marshall & Rossman, 1996).

Prior to conducting the oral interviews, the purpose of my research was explained to the Park View School of Nursing graduates while they were in a group setting. It was explained that their participation in the oral interviews were strictly volunteer, and that the researcher would not print information they did not agree with. By presenting the research idea in a group setting at the Park View Anniversary dinner, this allowed the Park View graduates time to personally assess if they were comfortable providing information about their history at Park View School of Nursing. When the individual graduates were called and ask if they were interested in participating in the research, it was again explained that their participation was strictly volunteer. Prior to the graduates agreeing to participate in the research, the 13 research questions that would be asked during the interview were told to each graduate. This was done in order for each graduate to assess if they were

comfortable answering the research questions. Many of the graduates that participated in the research volunteered prior to being asked.

Each oral interview was audio taped, and after completion of the interview, the tapes were taken to a professional transcriptionist. This was done to insure that all of the data from the oral interviews would be transcribed correctly. After the tapes were transcribed, each participant received a copy of the interview and was ask to review it for accuracy.

Age of Interview Participants

The age of the participants was a consideration for this research. The researcher looked at the history of nursing and nursing education at Park View Hospital from 1936 to 1969. To ensure accuracy, two graduates from each decade were interviewed. This provided the researcher with two sets of data that could be compared for validity. Prior to making the selection for interview participants, the researcher consulted with a 1968 Park View graduate who remains in contact with several of the former graduates. Therefore, she was aware of nurses that graduated during specific decades, was mindful of their probable willingness to discuss their experiences at Park View School of Nursing, and was conscious of any health problems they may have. Also, the researcher has been a nurse for twenty years and has extensive experience at assessing levels of orientation. Therefore, the researcher would have been able to assess if the graduates were not able to answer the questions due to problems caused by aging.

Another tactic that was used assess the quality of the memory was to ask simple orientation questions before and during the interview. Each participant was able to provide detailed and accurate directions to their house. Each participant was able to answer simple questions such as where they are from and how many children they have.

Weaknesses and Limitations of Film

Marshall and Rossman (1995) stated film has certain weaknesses and limitation. They state there are always fundamental questions that should be asked prior to using film, such as: What is the nature of truth? Does the film manipulate reality? Marshall and Rossman added that concern exists about the professional bias and the interests of the filmmaker. During this research, these concerns provided by Marshall and Rossman were considered. The North Carolina Nurses Association and the North Carolina Board of Nursing supported the film that was used for this research.

Summary

This chapter presented the strategies used to complete this study. This study sought to provide documentation of an area of nursing history that has not been previously explored. The historiography method was chosen for this research. The characteristics of qualitative research and historiography were included in the discussion of qualitative research. Information was collected through observation, in-depth interviews, historical documents, and film. The researcher used techniques that show validity and credibility to the research. The chapter concluded with a discussion of research limitations that may decrease the reliability of the research. The following chapter discusses the history of nursing and nursing education at Park View Hospital.

IV. Results of the Research

This historical research examines the history ofParkViewHospitaland the history of nursing education at Park View School of Nursing. ParkViewHospitalwas located inRocky Mount,North Carolinafrom 1914 to 1971. The foundation of the chapter is laid by providing historical events that helped shape the city ofRocky Mount. The history of medicine inRocky Mountand the devastation of the 1918 Spanish Influenza are also presented. The chapter concludes with an in depth historical look ofParkViewHospitaland Park View School of Nursing. The research includes information obtained from newspaper articles, Park View historical documents, and interviews with Park View School of Nursing graduates and a former Park View physician.

History ofRocky Mount

The city ofRocky Mountis located in northeasternNorth CarolinainNashCounty. TheTar Riverwinds through the county with a large reservoir in the southeast. Numerous creeks, such as Toisnot Creek and Beaverdam Creek in the south, Peachtree Creek in the northwest, Swift Creek in the northeast, and Sapony andStoney Creekin central Nash, supply water and powered the many mills that spurred settlement (Fleming, 1998).

The first few decades inNashCountywitnessed residents settling near rivers and creeks, often building gristmills. In 1818, the second cotton mill in the state was built at the Falls of theTar River, which was then inEdgecombeCounty. Half a century later, the county line moved east and Rocky Mount Mills became part ofNashCounty(Fleming, 1998).

The biggest change toNashCountyoccurred between 1830 and 1840, when theWilmingtonto Weldon railroad was completed. The first train went through to Weldon onMarch 9, 1840, after construction reachedRocky Mountin 1839 fromGoldsboro. The railroad would shape the county with spur lines forming more communities, and the repair shops would result in a population burst at the end of the century. At the turn of the century,Rocky Mountwould become known as a railroad boom town (Fleming, 1998).

According to Fleming, the county seat ofNashvillewas thriving by mid-century with numerous merchants. Many residents were farmers on the eve of the Civil War, when the county population reached over 11,600. The war came toRocky Mountin July 1863 when the Union forces led by Major Jacobs raided the Rocky Mount Mills and the railroad depot. After evacuating the mill, the Yankees burned it down and captured a train before destroying the railroad bridge and part of the tracks.

After the war,Rocky Mounthad grown enough to become incorporated in 1867. Then in 1871, under disputed circumstances, the county line between Nash and Edgecombe was moved over a mile from the river at the falls to the railroad. When the Atlantic Coastline railroad set up its repair shops inRocky Mountin 1899, the population grew from less than 900 to over 3,000, and by 1920, the population was over 12,000. By the 1950s,Rocky Mountwas the largest bright-leaf tobacco market in the world. During this time up to present day,NashCountyis active in agriculture, producing sweet potatoes, corn, tobacco, cotton, and peanuts. Livestock includes beef and dairy cattle, swine, and poultry farms (Fleming, 1998).

In 1904, the Rocky Mount Hosiery Company opened with over 200 machines and employed over 200 people. The company produced 800 pairs of hose a day. Fleming (1998) added that in the 1950s travel

guide,Rocky Mountwas known for four things: the home of Kay Kyser, Meltons's Barbecue, the June German, and Bugs Barringer. Kay Kyser was a popular musician, and Bob Melton had established one of the oldest and most successful barbecue restaurants in the East. The June German began in 1880 as a summer dance and became the social event ofNorth Carolina. Bugs Barringer recorded it all with his camera asRocky Mountcontinued to grow as the largest city in the northeasternNorth CarolinabetweenRaleighand the coast (Fleming, 1998). In 1961,Rocky Mountbusinessmen James Gardner and Leonard Rawls opened a hamburger stand onNorth Church Street. It was named for Wilbur Hardee, who began to charcoal grill burgers the year before inGreenville. This was the first of what would become a national chain of fast-food restaurants (Fleming, 1998).

The History of Medicine inNashCounty

In June 1837, Dr. John A. Missis established a practice at the Falls of the Tar River, advertising himself as a "Thompsonian Botanical Physician." It wasn't until after the Civil War that the school trained, licensed physicians that we know today emerged. In the early days of medicine in NashCounty(19th century), a doctor was called only when the family feared a patient's life was in danger. Before medicine was centralized, the doctor's office was seldom used as a surgical location, and much of the surgery done during this time was performed on the patient's own kitchen table or bed (Teagarden, Wiggins, and Helms, 1978).

The doctor's essential tools, anesthetics, and pharmaceuticals went with him on his calls. By day, the doctor rode his horse or in drove a buggy followed a summoner to a distant farmstead, and by night he followed a lantern light. In the doctor's bag included his basic medicines, which were usually in quart bottles. The drugs were usually Tincture of Nuxvomica, Elixir of Iron, Quinine and Strychnine, Syrup of Sarsaparilla, Laudanum, Essence of Pepsin, Paregoric, and capsules of Calomel.

According to Teagarden et al. (1978, p. 4) a documented conversation with Park View Hospital physician, Dr. C.T. Smith on July 7, 1977, revealed how medicine in Nash County was utilized in the late 19th century.

"It is a matter of fact that when some of the liquid medicine was left over, the doctor poured it into a common bottle. This was prescribed and given when the doctor didn't know what was wrong with the patient nor what he was giving. This was not entirely a placebo. It might have been considered a shotgun prescription – the doctor had confidence in medicines and hoped with the shotgun some of it would work."

In the fall of 1918,Rocky Mountwas suddenly in the midst of an epidemic such as has never been before seen in the city. It was the Spanish influenza, and it later became known as the, "Great Flu Epidemic of 1918." During this time,Rocky Mountwas also laboring with the war effort. Battle, M. (1968, March 17). The RockyMountEveningTelegram. (No page number available.)

In theMarch 17th, 1968article published by the Rocky Mount Evening Telegram, Dr. Margaret Battle discussed her memories of the great flu epidemic of 1918. Dr. Margaret Battle was a Park View physician and was the first female OG/Gyn inRocky Mount. Dr. Battle stated doctors were seeing 100 patients a day. In some houses every member of the family was sick. It you were well, you went next door to help the neighbors. If the fever was very high (105), it burned out the infection, and the patient would usually recover. But if there was almost no fever, the patient usually died in three days. Pregnant women were the hardest hit by the Spanish influenza. Miscarriage was the rule; following this, the infection spread and the mother died. Many parents lost two children in one week and entire families were wiped out. Dr. Battle remembered a heart-rending memory of finding one mother so sick she did not realize her two children were dead in the same room. Battle, M. (1968, March 17). The RockyMountEveningTelegram). (No page number available).

According to Dr. Margaret Battle, hospitals were overflowing with influenza cases; beds were even set up in the reception rooms. She stated help was scarce, so young boys and old men were serving as orderlies. Teagarden et al. (1978) further added that the flu was combated with cough syrup, quinine, aspirin, and phenacetin. Funeral processions were passing all day long. A gentleman by the name of C.M. Battle remembers seeing 27 caskets lined up at the depot at one time, waiting to be shipped out. An emergency hospital was organized in theMethodistChurch, and the newly functioning Red Cross managed it. Nursing was not easy in the emergency hospital; five patients died in a single night. Dr. Battle concluded it was the saddest timeRocky Mounthad every experienced. Battle, M. (1968, March 17). The RockyMountEveningTelegram). (No page number available).

The History of Park View Hospital Introduction

ParkViewHospitalopened its doors onJuly 1, 1914and closed in May of 1971; thus, serving the citizens ofRocky Mountfor over a half a century. For 57 years,ParkViewHospitalwas able to keep up to date with modern facilities and medical equipment. In 1914, Park View opened with a 25-bed capacity, when it closed in 1971;ParkViewHospitalhad 145 beds. Park View witnessed the effects of the 1918 Spanish flu and four wars. During its reign as the largest hospital inRocky Mount, it opened a training school for nurses, survived financial difficulties, and built several facility expansions including a new operating suite, a larger obstetrical facility, and a more modern kitchen. Through the solid foundation of Park View Hospital and the hard work of several Park View physicians, the Boice Willis Clinic was established which continues to serve Rocky Mount today.

ParkViewHospital1914 – 1939

At the turn of the 20th century,Rocky Mount had only one hospital, theAtlanticCoastLineHospital. TheAtlanticCoastLineHospital operated with 30 beds. This served the employees of the railroad and their dependents, and railroad industrial compensation cases. The second hospital inRocky Mount, which was a forty-bed hospital, opened in 1913 and was called the Rocky Mount Sanitarium (Teagarden et al. 1978).

Due to the lack of surgeons, hospital beds, and nursing care, many patients fromRocky Mountwere transferred to one of two hospitals inRichmond,Virginia. The train named “Eighty” which leftRocky Mountevery afternoon usually had one or two bed-ridden patients that rode in the baggage car toRichmondVirginia. Although the patients received excellent care inRichmond, frequently the trip was extremely difficult for them (Teagarden et al. 1978).

In 1913 the population ofRocky Mountwas 10,000. Several independent general practitioners practicing inRocky Mountrealized as their practices grew and more and more people turned away from home remedies, the Rocky Mount Sanitarium and theAtlanticCoastLineHospitalwould soon be inadequate to meet the requirements of the people living inRocky Mount. More hospital space was needed for the treatment of serious illnesses and the delivery of difficult obstetrical cases. Johnson, B. (1951, December 16). The RockyMountSundayTelegram, p. 13A.

FiveRocky Mount Physicians broughtParkViewHospitalinRocky Mount,North Carolinainto existence. Between 1912 and 1913, Dr. Joseph P. Whitehead, Dr. Ivan P. Battle, Dr. Richard H. Speight, Dr. Emile B. Quillen, and Dr. Joseph P. Speight incorporated themselves with Dr. George Ben Johnston and Dr.A. Murat Willis ofJohnston-WillisHospitalinRichmond,Virginia(Battle, n.d.). Dr. J.P. Whitehead was noted for being the prime force behind the establishment ofParkViewHospital. Dr. Whitehead along with his father had the largest practice inRocky Mountain was one of the first two to see the need for additional medical facilities in the city. Dr. Ivan P. Battle had much of his practice among the Rocky Mount Mills employees. He took part in the founding

ofParkViewHospitalin order to give his patients the benefits of hospital treatment. Johnson, B. (1951, December 16). The RockyMountSundayTelegram, p. 13A.

Carneal and Johnson of Richmond drew the plans forParkViewHospitalin 1913, and S.S. Tolar of Rocky Mount Was the contractor. The building was completed in June of 1914. Miss Mamie Rice, a graduate of the Johnston-Willis Hospital School of Nursing arrived to help organize the newParkViewHospital. With Miss Rice came with three nurses from the Johnston-Willis staff, and two student nurses who had served their probation period at Johnston-Willis. These six pioneers and three more student nurses who had applied for admission at the Johnston-Willis School of Nursing cleaned Park View Hospital while furniture and supplies were installed. Due to the efforts of these nurses,ParkViewHospitalwas ready for opening day onJuly 1, 1914. At this time, Park View was a 25-bed hospital (Battle, n.d.)

Realizing that surgical cases would be needed to help finance the new institution, the local physicians approached Drs. George Ben Johnston and A. Murat Willis of Richmond with the suggestion that they join the Park View medical staff. Both Virginia surgeons had for years been treating Rocky Mount patients that were referred to them by local Rocky Mount physicians. Both Dr. Johnston and Dr. Willis readily accepted the invitation to become consulting surgeons at the newly developed Park View Hospital. Johnson, B. (1951, December 16). The Rocky Mount Sunday Telegram, p. 13A.

Dr. E. S. Boice, who had been on the Surgical Staff of Johnston-Willis Hospital in Richmond for five years, arrived on opening day to be the surgeon in charge of the new hospital. Park View Hospital which was a brick and cement facility built on Falls Road at the corner of Hickory Street officially opened its doors ready for patient care on July 3, 1914. ParkViewHospitalwas noted as “a child born of necessity”. On the flysheet of the first volume of case records of the hospital is the following (Battle, n.d, p. 2).

1914 Supt: Miss Mamie Rice, R.N.

Medical Staff: J.P. Whitehead, M.D.

I.P. Battle, M.D., Secretary

R.H. Speight, M.S., Treasurer

E.B. Quillen, M.D.

J.P. Speight, M.D.

Surgical Staff: George Ben Johnston, M.D., FACS, Consulting Surgeon

Murat Willis, M.D., Consulting Surgeon

Edmund S. Boice, M.D., Surgeon in Charge

Interns: J.C. Walker, M.D. –MedicalCollegeofVirginia– 1914

R.L. Ozlin, M.D. –MedicalCollegeofVirginia– 1914

Park View's first patient was listed on the case records as a Miss Abrams. The details of her case are not available, only that she was admitted onJuly 1, 1914two days before the hospital was officially opened. The first operation listed on the operating room records was a tonsillectomy performed by Dr. Boice and assisted by Dr. E.B. Quillen. Johnson, B. (1951, December 16). The RockyMountEveningTelegram, p. 13A).

In the 1951, December 16th issue of the Rocky Mount Sunday Telegram stated if Park View was a hospital born of necessity, then its Negro hospital was a child born of emergency. ParkViewHospital had been operating only three months when Dr. Whitehead brought in a Negro, dwarfed woman requiring a Cesarean operation. After the child had been delivered, the woman was made comfortable in the only available room in the basement. Her child was dead at birth, but even in death the baby had itself given birth to theParkViewNegroHospital.

The following information was taken from a booklet entitled, The Park View Hospital. This booklet was dated October 1914 and was available to the public and to Park View patients. (Booklet courtesy of the family of Willie Poytress Coggins, booklet reprinted by the Park View Hospital Nurse's alumnae association, pgs 5,7,12,13). (Mrs. Coggins was one of Park View's first surgical patients.)

ParkViewHospitalis completely equipped for the care of all cases of general medical and surgical cases, both white and colored, except those suffering from insanity or contagious diseases. Park View has a hot water system of heating that insures an equable temperature throughout the building. Each room is well equipped with electric lights and a special attachment for an electric fan, a feature greatly appreciated during the summer months. All rooms are outside rooms, unusually large, and well ventilated and lighted.

The two main floors of Park View Hospital are reserved for white patients, while in the basement, in addition to the kitchen, the nurses' dining room and the X-ray and laboratories, there are two wards comfortably fitted up for the accommodation of colored patients. On each of the upper floors is a large sun parlor for the use of convalescents.

Hospital expenses are determined chiefly by the choice of a room and by whether or not a special private nurse is desired. All patients receive the same food, care and general nursing regardless of whether they have a private room or share a room with some one else. A private room, which includes board and general nursing, is from $3.00 to $4.00 per day, depending upon the size and location of the room. A bed in a room with one other patient is $2.25 to $2.50 per day. A bed in a room holding more than two patients was $2.00 per day. Colored ward rates are $12.50 per week, or $1.80 per day. A colored nurse is in charge of these patients under the direction of a head nurse of the training school.

Since the Hospital is dependent entirely upon the income from patients for its support, it is impossible to maintain free beds. However, in the case of worthy persons unable to pay a professional fee,

provided sufficient money for Hospital expenses can be raised, all necessary medical and surgical attention will be given willingly free of charge.

Charge for a Special Private Nurse varies according to whether a pupil nurse from the hospital staff or a graduate nurse is desired. The charge for a pupil nurse is $2.50 a day, board included. The regular rate for graduate nurses is $25.00 per week. The Hospital also charges $1.00 per day for board of a graduate special nurse.

In case of operative work, the customary "Operating Room Charge' is made to cover the use of the operating room and equipment, the anesthetic, etc. This charge varies from $5.00 to $10.00, depending on the nature of the operation and the anesthetic employed. These charges do not include the surgeon's fee in case of operation, or the attending physician's fee in non-surgical cases.

In 1916, the original seven doctors who owned the hospital sold the institution to Drs. Boice and Willis, and the Boice-Willis Clinic was formed. Dr. Boice set up this clinic as a model of the Mayo Clinic inRochester,Minnesotawith a group of doctors with specialties in each branch of medicine and surgery (Battle, n.d.). During this time,ParkViewHospitalwas operated as a private institution. (Bulletin of the Park View Hospital School of Nursing, 1955).

For the first five years of operation,ParkViewHospitalwas managed by two the owners, Dr. Boice and Dr. Byrd Charles Willis. Dr. Willis handled the books and records. Then, by accident, Park View became the first hospital inNorth Carolinato turn the business aspects of the institution's operation over to a non-medical administrator. Johnson, B. (1951, December 16). The RockyMountSundayTelegram, p. 13A.

Marius E. Winston, a Bertie County school principal and farmer, suddenly found himself considerably in debt when a flood inundated his tobacco and cotton crops in 1919. His wife had been a patient at Park View for some time and the medical bills added to his burden. On a hunch he gave notes for the majority of his debts and then applied for the position of business manager at the hospital in order to pay off the notes. Winston was given the job. Winston had planned to stay atParkViewHospitalonly long enough to work out of his financial straits; however, he remained in this position until 1930. J. Lyman Melvin succeeded Winston in the post of administrator at Park View in 1930. Mr. Melvin served as Park View administrator for 42 years until the hospital closed in 1971. Johnson, B. (1951, December 16). The RockyMountSundayTelegram, p. 13A.

Two other individuals who are credited with the Park View's success in its early years are Miss Mary Mason and Miss Mabel Barrett. Miss Mason "specialized" in practically everything concerning the hospital that was nonprofessional. Among her duties were answering the phone, keeping books, receiving payments, taking dictation, handling correspondence, and acting as "runner" for the patients. Miss Barrett distinguishes herself by having served the hospital longer than any of the other non-medical staff members. For several years she was employed as Park View's first laboratory technician. The she acquired the position of record librarian. Johnson, B. (1951, December 16). The RockyMountSundayTelegram, p. 13A.

According to the December 16th, 1951 issue of the Rocky Mound Sunday Telegram, no story on Park View would be complete without some mention of "Mother" Hancock, the hospital's first full-time dietician. Mother Hancock was remembered as a diminutive lady of about 70 who wore misshapen woolen bed socks summer and winter in the place of shoes. She sat on a high stool, wore no glasses, but saw everything. She was noted for keeping a running commentary on whatever came to mind while the food was being prepared and sent to the floors. For many it was noted that it was a sad day when "Mother" Hancock was replaced in favor of a college-trained dietician.

In 1919, the Boice-Willis staff hired as an associate, Dr. C.T. Smith. Dr. Smith's specialty was internal medicine. Dr. C.T. Smith taught various lectures for the Park View School of Nursing from 1920 to 1969, and was best remembered for his loyalty and dedication to nurses. At this time, all surgical patients were taken care of by Drs. Boice and Willis, and Drs. Quillen and Looney treated eye, ear, nose, and throat patients. Throughout the 1920s, the Park View medical staff expanded. Dr. W.B. Kinlaw joined the clinic to assist Dr. Smith. Dr. N. P. Battle became a resident in surgery (Teagarden et al. 1978).

In 1924 a non-profit corporation was organized, and Duke Endowment approved Park View hospital. Ownership of the buildings remained the property of Drs. Boice and Willis until 1939. At that time the members of the Board of Trustees of the operating corporation purchased from the doctors all buildings and equipment for the use of the community (Teagarden et al. 1978).

Ten years after Park View opened its doors, the hospital made its first sizable advance. In 1924, fourteen rooms were added to the original 25. An apartment building located across the street from the hospital was purchased as a student nurses home, and the former nurses' home that was a large building directly behind the hospital was converted into a 21 bed Negro hospital. As early as 1929 the Board and the Boice-Willis Clinic were caring for as many as 1800 patients a year, as high as 25% being charity work. With 63 employees, 39 of whom were student nurses; operating expense for one year was $ 71, 000. The average patient's stay was 12 days. At the end of the 1920s, patients were coming for treatment fromLouisburg, Norlina, Warrenton,Halifax,Enfield,ScotlandNeck,Northampton, Ahoskie, Aulander,Windsor,Plymouth, Williamston,Bethel, Farmville,ElmCity, Bunn, andGreenville. There were medical facilities inWilsonandGreenville, as well as Roanoke Rapids, but these were private hospitals (Teagarden et al. 1978).

According to Teagarden et al. Park View's policy was the hospital was to take every patient that came to its doors regardless of condition, if he needed hospitalization; in other words there was no selection of customers on their ability to pay, nor refusal to serve those who could not pay, nor refusal to serve those who could not pay or whose reputation was not known. If an injured or desperately ill patient was brought to the hospital, he was treated first; his financial status investigated afterwards. He was not sent out of the hospital until he was physically able to go, regardless of whether or not he was able to pay.

By 1930ParkViewHospitalwas again over crowded. At a meeting of the directors, the decision was reached to build an addition to the original hospital building. By the end of the year the three-floor fire proof structure had been added. Park View now had 100 beds and was one of the largest hospitals in the eastern part of the state. Johnson, B. (1951, December 16). The RockyMountSundayTelegram, p. 13A.

In 1933 additional rooms were built onto the nurses' home, doubling its capacity. It was felt at this time that Park View's facilities were adequate to meet the demand for the next several decades. However, changes did take place. Expectant mothers gave up the common practice of having their babies at home and began flocking to the hospitals. The advent of new medical techniques, new machines, and new medications attracted thousands who had never smelled the scent of ether in a hospital corridor. Johnson, B. (1951, December 16). The Rocky Mount Sunday Telegram, p.13A. Also,Rocky Mountwas still feeling the after-effects of the 1918 "Spanish Influenza" epidemic, including a high incidence of pneumonia, encephalitis, sinusitis, nephritis, pleurisy, and empyema. There were also numerous cases of malaria and tuberculosis (Teagarden et al. 1978).

Oral Interview with Park View physician, Dr. Lewis Thorp

I came toRocky Mountin 1953 to join Boice-Willis Clinic atParkViewHospitalafter completing my training at the new hospital inChapel Hill. Boice-Willis Clinic's membership consisted of Drs. Boice and Willis, Dr. Clayborn

Smith, Dr. John Smith, Dr. Tom Suiter, Dr. John Chambliss, and Dr. Newsome Battle. Dr. Battle's wife, Dr. Margaret Battle was in practice in her home, but was not part of the clinic. Dr. Large was an urologist who worked in the basement and was also a Health Officer. Drs. Frohbose and Fish came shortly after I did, and Dr. Julian Brantley had been there for a short time.

ParkViewHospitalhad been the property of Drs. Boice and Willis since about 1916. Drs. Boice and Willis were traveling by train fromRichmondwhen they stopped to stretch their legs onHickory StreetinRocky Mount. The train was a steam engine and it had stopped for coal and water. They found that Park View was owned by five family practitioners and that there was another hospital in town, the Rocky Mount Sanitorium, which was owned by Dr. Kornegay. It was discovered the Park View required a surgeon. The hospital was the workplace of a surgeon particularly in those days. I am told that Drs. Boice and Willis hocked everything they could lay their hands on and bought the thing, and shortly after, started a clinic modeled after the clinic of Dr. Charles Mayo inRochesterwho was a friend of theirs. Dr. Mayo came down and visited at least once and had operated at Park View. Drs. Boice and Willis went back toRochestereach summer for a fresh up. These were exceptional people.

Dr. Willis had about retired when I came. Dr. Boice went on for many years and was over 80 when he quit operating. Both of them, and Dr. Battle too, could be found most any time of the day or night in a scrub suit with brogans flecked with blood and plaster material from working in the operating room. Dr. Boice was a gymnast of sorts in school, and continued to work out regularly and was lean and vigorous. He worked all the time. His wife and a device on a radiator in their home into which she would put his plate at dinner, and he would eat it when he got home. If you saw him eating in the hospital, you had to inquire as to which meal it was because it might well be out of time.

Dr. Willis was a businessman and had been an insurance salesman before he went into medicine. He also had been trained in pathology. There was no pathologist around and they did their own frozen sections and would do their own autopsies. We also did this as well when I first got there.

Dr. Clayborn Smith, who signed on shortly after Drs. Boice and Willis, established the first laboratory atParkViewHospital. Dr. Smith finished his training at theUniversityofPennsylvania. He was really the first scientific physician in this part of the world. He kept rabbits and mice and animals to use for lab tests, and he was required by the referring physicians to have an entirely hospital base practice. He said that he got the sickest ones, so a lot of them died, and that didn't help his reputation any to start off with.

This was a wonderful climate for a young doctor to come into and over the years I learned a great deal more from their preceptoring that I had in school. The carriage days of medicine to the space age days have happened in my lifetime, which is like 45 or actually 50 years of being in medicine.

ParkViewHospital1940 - 1971

In 1944, ill health forced Dr. Willis to retire. Therefore, the full brunt of surgery fell upon Drs. Boice andBattle; they were assisted, whenever possible, by various surgical residents until Dr. Harry G. Fish was invited to join the medical staff (Teagarden et al. 1978). Also in 1944,ParkViewHospitalbegan to become over crowded. Prior to 1944, the graduate nurses housing and the Boice-Willis Clinic were located in the hospital. Therefore, to relieve some of the pressure and to make more space for patient beds, theA.E.Shorehome on Falls Road was purchased and changed into a home for graduate nurses. Then the Old Massenburg home, across the street from the hospital, was bought and converted into doctor's offices for the Boice-Willis Clinic. Johnson, B. (1951, December 16). The RockyMountSundayTelegram, p. 13A.

Early in 1948 talk began on plans for once again expanding the capacity of the main hospital building. Of particular urgency was the need for more space in which to handle obstetrical cases. In 1951, Park View built a new annex that added 40 more beds, bringing the total to 115 beds and 25 bassinets. The new addition also included a new enlarged operating suite, including a recovery room, a larger obstetrical facility, and a larger kitchen and laboratory. A second annex with 56 beds opened onDecember 31, 1956. Johnson, B. (1951, December 16). The RockyMountSundayTelegram, p. 13A.

It was documented in the Bulletin of the Park View School of Nursing (1955) thatParkViewHospitalwas a member of the American Hospital Association, the North Carolina Hospital Association and fully approved by theAmericanCollegeof Surgeons and the American Medical Association. The hospital was governed by a board of ten trustees made up of leading men and women in the community. It was a non-profit, non-stock institution operated for the benefit of the sick in the community. In 1964,ParkViewHospitaladded 13 more beds, opened a new emergency department, established a pediatric department with seven beds, and opened a chapel for patients and visitors (1964, June 7). TheRocky Mount,N.C.Telegram, p. 3B.

Also in 1964,ParkViewHospitalreceived two advanced pieces of equipment, a respirator and a mobile emergency cart. The respirator was called a Bird Respirator and it was documented as having five uses: It supplied artificial respiration through a tracheotomy tube; it helped patients with chronic lung disease; it helped in treatment of a crushed chest; it helped in treatment of asthma, and it could be used for the patient who has difficulty breathing after an operation (1964, June 7). TheRocky Mount,N.C.Telegram, p. 3B.

The emergency mobile cart was located in the emergency department, and it was documented in the June 7, 1964 Rocky Mount, N.C. Telegram that the mobile cart contained medicines, equipment and supplies a doctor needed to treat a person having a heart attack. The cart had medicines necessary to begin immediate treatment, intravenous fluid, equipment to breathe the patient and to open the airway (tracheotomy) and surgical equipment to open the chest to expose the heart for open-heart resuscitation. The cart also has a direct current defibrillator, which is used to restore the proper heart action in the case of a heart attack (1964, June 7). TheRocky Mount,N.C.Telegram, p. 3B.

OnJune 18, 1965, the Nash County Board of Commissioners announced the formation of a hospital study committee. The committee's purpose was to determineNashCounty's medical needs and how they should be met. In November of 1965, the study was complete with a recommendation for a new 350-bed hospital for the citizens ofNashCounty. OnApril 23, 1966, voters approved a bond issue for a 300-bed hospital (Teagarden et al. 1978).

Therefore, in 1971, due to an aging building and a faster moving medical technology,ParkViewHospitalwas replaced with the more modernNashGeneralHospital. OnMay 16, 1971, the first patients were admitted toNashGeneralHospital, with the majority of those being transferred from Park View. All Park View assets were turned over to Nash General and it was documented that Park View bowed out graciously as it assisted the newcomer that became its replacement (1971, May 16). TheRocky Mount,N.C.Telegram, p. 8F. It was also documented (Battle, n.d.) thatParkViewHospitalis just a fond memory, but Park View still occupies a warm

place in the hearts of area citizens in general. It's gone now, the building having been razed after more than a half a century of feverish activity, its contributions and legacy of patient care still live in day to day operation ofNashGeneralHospital.

Oral Interview with Park View physician, Dr. Lewis Thorp

Ventilators were an interesting thing. At the start, the only way you could assist someone to breathe was with a volume respirator, which was large electric bellows that held 2,000 ccs of air, and it had no adjustments on it. You could not control volume, pressure, flow rate, or anything else, and you had to have a trach to make it work. It stayed in storage most of the time. Then came on the scene atParkViewHospitalwhat we called a “green box bird.” The bird respirator was a green box, maybe 8 x 10 inches of transparent green plastic, and it had basically three adjustments on it for volume, flow rate, and pressure. It proved to be a bonanza particularly with people with tracheotomies. We also learned you use it to deliver bronchodilators and other medicines into the bronchial tubes, and eventually we ended up with a respiratory therapist and with several of these devices.

One of the problems we had with this device was that it didn’t sigh. When one seeks to replace normal breathing, he must replace the sign as well because that is what we do in our normal breathing without realizing it. Periodically, we take a deep breath. The reason the company put this green box bird in clear plastic was that any doctor worth his salt would have taken it apart to see how it worked, and these engineers were smart enough to fix it so that you could watch it work without taking it a part and ruining it.

In those days, there was a pool of private duty nurses who were available by telephone through a central agency. These nurses did home nursing and came into the hospital and did hospital nursing. There were no ICU and CCU specialty care back then. These private duty nurses would come in when somebody was very sick, or we had a device of some sort that needed constant care. The patient would hire one of these private duty nurses.

These private duty nurses were generally excellent bedside nurses who knew how to make you comfortable. However, every new piece of equipment that I’ve ever seen introduced into the hospital was met with resistance from the nursing staff, particularly the private duty nurses. I think it was because their work was so stressing and fast, and required such immediate response, that the introduction of something else to learn was frequently looked on as an intrusion rather than a help. Although, most of these devices were designed to help. For instance, I can recall the first cardiac monitor. Well, the first one was improvised from a journal article. I read the article and bought the parts including some vacuum tubes like you put in a radio and John Gerlinger, who was a genius pharmacist, who could do anything, put it together for me in a cigar box. It had a little dial on top that oscillated with each heartbeat, and you plugged it into the wall and put two electrodes on the patient, and it would monitor his heartbeat. It was more novelty than anything else.

I went over to the colored hospital; that was another thing, we were segregated, and so there two sections to the hospital. I found a student nurse sitting with a dead man. She has this monitoring device on him and it was oscillating regularly at about 110. He was not breathing, cold, stiff and she had been sitting there her whole shift watching him and reporting this 110 pulse. That’s when we found out that if you plugged this thing in backwards to the polarity in the wall that it would try to count alternating current and it could only count to 110.

When Park View finally bought a cardiac monitor with a screen on it that you could see the EKG running across the thing, it was about as big as a piece of furniture and we had to put it in a private room with a private duty nurse. I walked by one night and saw a nurse with a handkerchief over the thing. I asked her if it was broken and she said no, it just made her nervous.

So later along, Dr. John Smith became Vice-President of the National Heart Association, and was the local Mr. Heart. He was wrapped up in issues like cholesterol and electrocardiography. In about 1965, the concept of Special Care Units evolved and a nurse named Moss who was working with Dr. Smith started this Special Cardiac Care Unit. This unit had several beds in it and several monitors, so we were able to admit coronary patients to that Special Cardiac Care Unit. That was a big step up in the quality of care.

The equipment hardware over the years had sort of come on one piece at a time. Two or three memories about it included the first defibrillator that was brought intoParkViewHospitalby Dr. John Chambliss. None of us including Dr. Chambliss had ever defibrillated a patient. The game plan was that he was going to call all the doctors when he had a case that needed defibrillating and we would go and watch him. So, he eventually had an old man who was in atrial fib and congestive heart failure, and was obviously going to die unless he converted his atrial fib. So, we all gathered in this patient's room. Here was this big machine, about fourteen nurses, and all the medical doctors on staff in this little bitty room with this poor old fellow who was quite sick and quite frightened. So, John put the grease on the paddles and rubbed them on the patient's chest and got ready to push the red button and told us all to stand back when one of the little nurses said just a minute doctor, she said look at the monitor. The monitor showed normal sinus rhythm. We had scared him so badly that he converted and we didn't get a chance to shock him. I can remember being disappointed in him for doing that. That wasn't a very rational attitude, that was what I thought.

Dr. Suiter went to Duke for a year and studied hematology, so among the things he brought back was a flame photometer, which was a device to make electrolytes; sodium, potassium, etc. That was nice but none of us knew anything to do about it, and in order to test it, I had a patient who was unconscious with what we thought was a liver coma, an alcoholic lady. I think the reason we used her blood was because it wouldn't bother her. So we tested it, and to our surprise, her sodium was way, way low. We didn't have any hypertonic salt and we didn't know much else to do, so I calledChapel Hill, and they suggested we get a solution of hypertonic salt. Well, we couldn't find any, so Gerlinger went to the kitchen and got some salt and measured it on his pharmacy scales for half the deficiency. We calculated how much it would take to correct it, got half of it, and he boiled it to sterilize it and put it in a bottle of IV glucose water and we ran it in. She woke up, wanted to know what was for breakfast, and began to eat. We calculated her sodium and it was exactly half of the deficiency that we had calculated. From then until now, we have been working with electrolytes, and it has proven to be a tremendous asset.

These were great days and great people. The job and the work were much, much harder than it is now. There were no emergency room doctors. We took call for a week, we were there 24 hours a day, and ate our meals in the hospital. Back then, $10,000 was considered a very handsome annual salary, and you could buy a Coke for a nickel. The machines we bought for the hospital were about $75.00 to $100.00 each. The economy was different. We didn't know it because we had live in it all along.

The History of Nursing Education atParkViewSchoolof NursingIntroduction

Park View School of Nursing was started the same year the hospital opened in 1914. Park View School of Nursing educated nurses until 1969; thus, graduating 55 nursing classes. In 1964, it was documented that Park View had graduated 503 nurses (1964, June 7). The RockyMountSundayTelegram. (No page numbers available).

The time required to successfully graduate from Park View School of Nursing was three years. The theory component consisted of the Fundamentals of Nursing, Nutrition, Anatomy, Chemistry, Microbiology, Biology, Pharmacology, Nursing History, Medical/Surgical, Obstetrics/Pediatrics, Operating Room, and Psychiatry. Nursing instructors taught the Fundamentals of Nursing, and the Park View physicians taught the majority of the classroom lectures. Park View student nurses received the majority of their clinical experience while staffingParkViewHospital.

Park View nursing students were required to attend class, complete clinical hours, and staffParkViewHospital. The majority of student nurses lived in a former apartment building located across the street fromParkViewHospital. A housemother lived in the dorm and knew where each graduate was at all times. The dorm rooms were inspected daily for organization and cleanliness. Student nurses were is class anywhere from1to 4 hours a day. During the 1930s and 1940s, student nurses staffed the hospital for 12 hours, and during the 1950s and 1960s, they were required to staff 8 hours. The first six months of nursing school was called the probation period. During this time students mainly attended classes and did very little clinical time. After six months, each student was evaluated. If there were no concerns with the student's performance, she would receive her nursing cap, bib, and scissors. The capping ceremony was a formal service that was held in a local church.

Park View student nurses were expected to listen to whatever the physician said, never question or talk back to a physician, and to not question a physician's order. If students had a question about an order, it was discussed with the nursing supervisor. Student nurses and registered nurses were expected to stand up when a physician walked into the room and give him her chair if she was sitting.

Student nurses were required to wear their student nurse uniform when involved in patient care and while in class. In the 1930s, students had to furnish their own uniforms by having them handmade; however, after this decade Park View hospital furnished all uniforms, meals, and books. Student nurses were not allowed to be married, their hair had to be off their collar, and no make-up or perfume was allowed. No student was allowed to have a car.

In 1969, Park View Hospital School of Nursing was forced to close its doors. The reasons were increasing costs brought on by the federal minimum wage law, the rising number of Medicare, welfare, and indigent patients, and the requirement of the State Board of Nursing that prohibited student nurses from working without the supervision of nursing faculty.

ParkViewSchoolof Nursing 1914 – 1939

ParkViewHospitalopenedJuly 1, 1914, and the Park View School of Nursing started on the same day. From 1914 to 1917, the nurses atParkViewHospitalwere acquired from other hospitals and nursing schools. However, in 1917, Park View began graduating nurses in sufficient amounts to meet the demands of the hospital. The nursing students did all of their study and work in the hospital and resided in a wooden building behind the hospital. The graduate nursing staff also lived in the building. (1964, June 7). TheRocky Mount,N.C.Telegram, p. 3B.0

In aDecember 16, 1951article in the Rocky Mount Sunday Telegram, the names of the first nursing class to graduate fromParkViewHospitalwere listed. Among the nurses in the first graduating class at Park View as Miss Sallie Shumate,Rocky Mount's long time City Health Nurse. Other members of the first class were Misses Grace Arundall, Jessie Cooper, Stella Swank, Roberta Hogan, Irma Fortune, Eva Mayo, Kathleen Mayo, and Martha Newman. The 1918 Park View nursing class was dubbed "The Orphans", largely because its members were three in number. These graduates were: Eva Cooper, Odessa F. Johnston and Elizabeth Woodson. The article stated that Miss Shumate recalled that all of the classes during those days were taught a night. The doctors who were responsible for lectures or demonstration let nothing stand in the way of their teaching. When delayed by a hunting trip, or, as was more often the case, by over-work, it was not uncommon for the lecturing physician to rout the prospective nurses out of bed for their classes.

A booklet dated October 1914; entitled The Park View Hospital provided a description ofParkViewNursingSchool. (Booklet courtesy of the family of Willie Poytress Coggins. Booklet reprinted by the Park View Hospital Nurse's Alumnae Association, pgs 10, 11).

The Training School is a leading feature of the Hospital and is made up of young ladies from the best families in the State, especially selected because of their fitness for the profession. The Hospital is thus assured of a constant and efficient corps of nurses, trained by its own methods and working harmoniously together, instead of being dependent upon an uncertain and constantly changing supply of graduate nurses, each following the methods of her particular training school, and not in sympathy with the Hospital.

The course given to the student nurses extends over a period of three years and offers a complete training in theoretical and practical nursing of medical, surgical, and obstetrical cases. Members of the staff supplementing the practical work under care of the superintendent will give a series of lectures and demonstrations in the various branches each year.

The 1951 article further stated that requirements for graduation were somewhat different at Park View nursing school in 1915 than they were in 1951. One of the requirements was that each student nurse must serve a specified number of hours on special duty, usually outside the hospital. Since hospitalization for obstetrical delivery was considered only in the most difficult of cases, carrying for a laboring mother and new baby was the way most student nurses accrued their special duty hours. When the Park View student nurse went on duty in an obstetrical case, she stayed with the job often as long as 24 hours. During that time she frequently cooked the meals and washed the clothes. After delivery of the baby, the student nurse bathed the mother and baby, and she completed her special duty requirement by cleaning the house. Johnson, B. (1951, December 16). The RockyMountSundayTelegram, p. 13A.

In 1917, an event happened that had an impact on hospitals and Schools of Nursing all over theUnited States. OnApril 6, 1917, theUnited Statesentered World War I, and immediately hospitals and nursing schools all over the nation began to feel the strain of the war. Physicians and nurses were needed on the European war front; thus, leaving civilian hospitals short staffed. Dr. B.C. Willis served at theNavalHospitalatNewport,Rhode Island. Miss Lula West, Superintendent of Nursing atParkViewHospital, and a group of nurses from this area served inEurope. They served at theBaseHospitalnumber 45 which was set up by the Richmond Academy of Medicine atToul,France(Battle, n.d.)

Oral Interview with 1936 Park View School of Nursing graduate Eunice Wood.

Well, I am 90-years-old and I entered Park View Nursing school in 1933. As far as our classes, we would get up, eat our breakfast, and go on the floor and do some morning care. We would bathe the people and get the room straightened up, and then we'd have class from 10 until 12. And then we would go back work in the hospital. Of course we had some classes in the afternoon.

We had to take some classes over at theSanitariumHospital, because I remember we had to walk over there from Park View. We had some night classes over at the Sanitarium. So, it was kind of spread out in other words. I remember we didn't have anyone at Park View that could teach Chemistry, so we went over toRocky MountHigh Schoolto take Chemistry. The Park View doctors taught most of our other classes, and I remember we practiced our shots on oranges. I remember when we gave shots we would have to take the pill, put it in a spoon, and put it over a fire to melt it. We would make it into a liquid and then draw it up in the syringe.

We made our own uniforms. We had to do this before we even went in training. I remember going to the store to buy the material to make my uniforms and aprons. I guess those uniforms lasted until we graduated, we were in school for three years, and cotton usually last a long time. I know my three years of nursing school didn't cost much; I don't think it was over $50.00. We worked 7 days a week, 12 hours a day. You didn't have off Sundays like they do now. Of course, they gave us a half a day a week. When you got that half a day would be up to the Supervisor of Nurses. And, of course, as I say, Saturday was just like any other day and so was Sunday. You worked everyday. I remember when you graduated you could work as a private duty nurse. Back then you would work from 7 to 7 and make $5.00.

As nursing students, we took temperatures, blood pressures, and gave the patients baths. And bedpans. You had to keep those bedpans clean, and you were supposed to keep those rooms clean too. We didn't mop the floors or wash linen, but we had to see that the bed was clean and that the dust was kept off, because you know dust can cause trouble.

Back then people didn't go to the hospital like they do now, you know, for everything. We took care of a lot of surgical patients, and of course, we had people with pneumonia, flu, and other things too. We didn't have much to treat pneumonia, and so many of them died back in those days. But, I remember we had to put some poulis on their chest. I don't know what in the world they put in that. All I know is that you made it up, kind of like making up dough, and you put it on their chest. We didn't have sulfur or penicillin, or anything like that until World War II. The patients just had to tough it out, and hopefully they lived through it. For most surgeries, people would stay in the hospital a week or about 10 days. If they had a baby, they had to say at least a week or 10 days.

Now, the hospital was separated back then, as far as blacks and whites. There was an old wooden building behind the hospital that was called the, "ColoredHospital." The colored hospital didn't have the convenience ofParkViewHospital. Back in those days, most of the time seems like to me, the blacks by the time they got to the hospital, they were practically dead. When we were student nurses we rotated through the colored hospital, we had to pull so many months over there. We treated them and did the things just like we would for a white person.

After graduation, Mrs. Wood worked as a private duty nurse, and she worked for Dr. Gorham for 10 years and Dr.------ for 20 years.

Oral Interview with 1938 Park View School of Nursing graduate, Corinna Hedgepath

After graduation, I worked as a private duty nurse. Back then, the hospital didn't have that many RN's due to the number of student nurses staffing the hospital. When we were in school, we spent three months in each specialty. We were required to work in the kitchen as a student. Nurses would teach us the basic skills, and the doctors taught the subjects. We went toRocky MountSenior High School for chemistry and physics. The hospital furnished all our books and meals.

As a student, you may be put on the floor on night duty with one nursing supervisor for the whole hospital. We gave total patient care like giving everyone a bath and all their medications. You could work in the hospital from7 pmto7amand then have to go to class. We would sleep in the afternoon. We did not have a day off, and we always worked 12-hour shifts.

We had to furnish our own uniforms because this was right after the Depression and there wasn't a lot of money. I received $5.00 a month from my parents, and I felt very blessed to have this. Dr. C.T. Smith set up a

trust fund in which student nurses could borrow from. We washed gloves, powdered them, and then sterilized them. We also made and rolled our cotton balls, and we made casts. Nurses would not start IV's, the physicians were the ones that started IVs. Nurses did carry stethoscopes, but there was one on the floor. You always stood when the physician walked into a room, and everything was very formal. You were not called by your first name, you were always addressed as, "Miss____.

We had very little hospital infections back then, and we didn't have antibiotics. We saw a lot of Pneumonia, which we used to treat with mustard plaster. This was a cloth that we put on their chest. We would also pack them in ice and put them by a window. We also saw a lot of Scarlet Fever and Small Pox. You would see the same patients for weeks at the time. Women were required to stay in the hospital three weeks after a hysterectomy, and thirteen days after delivering a baby.

After graduation, Corinna became a private duty nurse until 1940, at which time, she became a stay-at-home mother until 1956. She then returned to ParkViewHospitaland became the supervisor of the ColoredHospital, and in 1958, she taught medical nursing at Park View School of Nursing. In 1962, she worked in the Nursing Office as the Assistant Director until 1971 when ParkViewHospitalclosed. When NashGeneralHospitalopened in 1971, she became the manager of 3rd floor, and Mrs. Hedgepeth remained in this position until she retired in 1982.

Corinna is best known for being the last person to walk out ofParkViewHospitalwhen it closed in 1971. In a May, 1989 Rocky Mount Evening Telegram article (no page number available), Mrs. Hedgepeth is quoted as saying, " I was the last one to walk out, the beds were just like you left them." "To walk out that door for the last time was really lonely and sad."

Park View School of Nursing 1940 – 1969

During the years of 1940 to 1969, Park View School of Nursing witnessed many historical events, including three wars that involved theUnited States. During World War II, several Park View graduates joined the Army Nurse Corps. These 29 years witnessed the discovery of antibiotics andParkViewHospitalreceiving it first respirator and defibrillator. Sadly, these years also brought the assassination of President John F. Kennedy and the closing of Park View School of Nursing.

Oral Interview with 1945ParkViewSchoolof Nursing graduate Virginia Glascow

I graduated in September of 1945; I did not miss a single day during my three years of training. We started out with 27 in my class, and only 9 of us graduated. This was a time when you would see nurses joining the military after graduation; however, no one from my class did because the war ended.

The doctors taught most of my classes. Dr. C.T. Smith, Dr. N. Battle, Dr. Boice, Dr. Willis and Dr. John Smith, were the main ones that taught. We did have a nursing instructor and her name was Ms. Claiborne. I had one month training in the lab where I learned how to do white counts and urinalysis. We had to go off campus toRocky MountSenior High Schoolto take our chemistry. Our chemistry class was one night a week.

We worked 7 days a week, 12 hours a day from7amto7 pmor7 pm to 7 am. Some days we'd have at least 2 or 3 hours a day for class. So, if you worked7 pm to 7amyou still had to go to class. When you worked night shift, you had your assigned floor by yourself, and you called the night supervisor if anything came up.

There was one supervisor for the whole hospital and for the colored hospital. Each shift had a nursing supervisor that was responsible for 75 patients.

We had 25 patients. A typical day consisted of bathing each patient, getting them out of bed, helping them with breakfast, administering their medications, watering their flowers, dusting, cleaning bed pans, giving enemas, etc. Every patient received a 10-minute back rub. If someone had surgery after4 pm, we were not only were responsible for our floor, but had to recover the surgical patients. We never gave men urinals or put men on the bedpan, we would always have to ask the orderlies to do this. We could not catheterize men either. Usually the doctors would catheterize the men. There was no such thing as a "break." Many times you worked one hour past your required shift.

We could not work in the colored hospital until we had received ourOBtraining. This is because you may have to deliver a baby while you were there. The majority of time the physicians delivered the babies in the colored hospital, but sometimes the doctors didn't arrive in time. I also remember during myOBrotation giving the patients ether. You would drip ether onto a funnel looking mask that covered their face. You could only administer so many drops in a certain amount of time. The ether was dripped onto the mask with a medicine dropper and the mask had a filter. You really had to watch the clock because you couldn't give more than so many drops per minute.

We made all of our dressings. You would have to cut and then make them. For some of them, we would have to cut the cotton and put it in the gauze. You then folded them because there were certain folds you had to do. The student nurses would assist with autoclaving. All our IV tubing was rubber. There was no air condition; therefore, we would fill a bucket with ice and put it in front of a fan.

Everyday we would have Chapel at6:30 am. You had to be fully dressed in your uniform, and your hem line was checked with a ruler by the Assistant Supervisor of Nursing. Chapel lasted about 5 to 10 minutes, and we would take turns leading in scripture. We would pray and then go to the hospital for breakfast. Our Chapel service was held in the living room of the nursing dorms.

When I graduated, I made $132.00 per month, and that's for working twelve hours a day.

Oral Interview with 1946 Park View School of Nursing graduate Alice Bradley

When I was atParkViewNursingSchool, you had the option of joining the Cadet Nurse Corp. Because of the effects of World War II, they needed nurses so badly that they put up this Cadet Nurse Corp. Myself and a few others from my class joined. You had to go into the service during your last six months of training, and then you had to join the military. ParkViewHospitaldid accept the training received during those six months. But, since Park View accepted to train cadet nurses and get money from the government, then they had to kind of do what the government said do. Because of this, some things changed at Park View. One of the things that I remember was that you had to have a certain number of hours in class before you went out of the floor. Luckily, and I say lucky, the war had ended during our six months, so we didn't have to go.

When you were in the Cadet Nurse Corp, you received two Nurse Corp uniforms. I wore those tow uniforms to death. You were treated like royalty when you wore your Cadet Nurse Corp uniform. I can remember standing in line at a movie and they would come by and pick out all the service people and let them go to the front of the line. The Cadet Nurses would be pulled out of line with the service people. It was wonderful.

When I was 13-years-old, I fractured my skull and was a patient of Dr. Battle's. This is when I decided that I wanted to be a nurse, it was when I was a patient at Park View. I just loved the nurses, and I always said that I wanted to be a nurse.

Some of the things I remember when I was in school was because of the war, we had such a shortage of gloves, like rubber gloves, you couldn't get them. So, when you were on call in the operating room, you weren't just on call, you might as well say you had to work all day because you would have to stay and patch gloves. We would have to run water in them to see if they had holes, and if they did, we would have to patch them. Back then you had to do your own cleaning, I mean you had to go in and scrub when a patient was discharged. You had to scrub everything in that room, and the nursing supervisor would wear white gloves and touch everything, so it really was clean.

Other duties we had when we were students was bedpans. The nursing supervisor would post your duties, and when you had utility duties, you knew what that meant, scrubbing bedpans. They had to be scrubbed everyday by hand, and then you sterilized them. That was the most hated job I had.

We worked 12 hours a day, seven days a week. We had 2 days off a month. Before you went on duty, your hands, nails, and uniform was inspected, they all had to be clean. At that time, you had to wear hairnets, you couldn't have your hair down. Well, you just went through inspection, but we also sang a song and we had prayer right before we went on duty. Seems like right at first we did nothing but classes most of the time, but then, we went right onto the floor. You were by yourself those 12 hours. One student nurse would be on the floor by herself. Sometimes you had an aide, and sometimes you didn't. You didn't have a ward secretary, and you had to write something every hour about your patient.

We didn't have a lot of orders on patients at that time because we didn't have a lot of these examinations. I remember the first time penicillin came out in a shot. The doctors were afraid of the complications or reactions, so when we first started giving penicillin, Dr. C.T. Smith would come over and give his own shots. Well, one night Dr. Smith couldn't make it over to the hospital, and he said, "I'm going to leave it up to you, and I am going to let you give him his penicillin shot." So that night, I gave that patient his penicillin shot, so the first nurse to give a penicillin shot at Park View Hospital was me.

I hate that they've done away with nurses wearing a cap. I was so proud of my cap. We didn't get a capping ceremony. They handed you a cap and said wash and stock these and have them ready to put on in the morning. Because of the war and shortages, we really felt like our class truly had it harder than other classes. It was just a hard time for nurses during World War II. Everything was rationed during the war. Sugar and food was rationed. We had to turn in our ration tickets to Park View while we were in training. I remember on night we made some sea foam candy, and it didn't turn out right, and boy, we had used all that sugar, we were having to get rid of that candy so nobody would know.

Nursing Curriculum at Park View School of Nursing

In a 1955 document entitled, "Bulletin of the Park View Hospital School of Nursing" detailed information regarding nursing faculty, lectures, objectives of the school, and policies of the nursing school was provided. It stated the aim of theSchoolofNursingof theParkViewHospitalwas to provide a basic course of instruction for the care of the sick and for the preservation and improvement of health. Special emphasis should be placed on the mental, moral, and physical health of the student in order that she might develop a better spirit of good fellowship and higher ideals for service. The curriculum of theSchoolofNursingendeavors to provide students with basic

professional education necessary to practice nursing in the home, the hospital and the community. It is also the objective of the School to aid in the personal development of the nurse during her three years of study.

The following was taken from the 1955 document, Bulletin of Park View Hospital School of Nursing, pgs 4 – 14.

Faculty – throughout the course, instruction is given by specially prepared teachers. Nursing principles are taught through classroom demonstrations, and practice is done under supervision of qualified instructors. Members of the medical staff of the hospital give instruction in various aspects of diseases. Qualified speakers from the surrounding community lecture on such subjects as public health.

Educational Facilities – Classrooms for lectures in science and nursing arts and a reference library are provided for the use of the School of Nursing. The reference library contains books and periodicals of special interest to students of nursing. The Nursing School owns a movie projector and provides adequate facilities for visual education. The application of theory to practice is made in the Park View Hospital where all major departments of medicine and surgery are represented. These departments include: Medicine, Surgery, Gynecology-Obstetrics, Urology, Orthopedics, and Eye, Ear, Nose, and Throat diseases.

Requirements for Admission – applicants for admission to theSchoolofNursingmust have graduated from an accredited high school and must present evidence of satisfactory completion of the course with an average of not below 80 during the 4 years of high school. The following subjects are suggested as ones that form a good background for courses taught in theSchoolofNursing. These courses include, four years of English, one year of Algebra, one year of plain Geometry, two years of one foreign language, two years of History, one unit of Science, and 5 units of electives.

At the present time foreign language is not required for entrance to the Park View Hospital School of Nursing, but those who wish to enter college for further study must have had this subject. One-half unit of each of sociology and economics, and one or two units of home economics are also recommended. One year of business arithmetic or math may be substituted for the unit of geometry. It is essential that the applicant have a thorough knowledge of common and decimal fractions, percentage, and the metric and apothecary systems of weights and measures.

Those who rank in the upper third of their high school class or who have had additional college study are preferred as students of nursing. However, the admission of an applicant is not determined solely by the quality of her academic preparation, but also by an evidence of fitness for the profession. Aptitude tests are given at Park View School of Nursing. Applicants must be between the ages of 17 ½ and 35, of average height and weight, and in good physical condition.

Appointments for personal interviews with the Director of Nurses will be arranged for each applicant before she is accepted as a student. This will give the applicant an opportunity to acquaint herself with the school and the faculty. Notification of acceptance is made after interviews and aptitude tests are given. Classes are admitted in September.

Expenses – a program is offered which includes complete maintenance and uniforms during the three-year course. This includes room, board, laundry of uniforms, and medical and hospital care. Students furnish their own white shoes and stockings, wristwatch and fountain pen. Each student is requested to pay eight dollars

($80.00) on admission to the school. This amount covers the cost of her books and breakage fee during the three years of her training. Each student will need a moderate amount of spending money.

Residence – there is one residence for students located across the street from the hospital. There are two reception rooms available to students at all times. The City Library is across the street from the nurses' home; students may use it at any time. The nurses' home has a housemother who is available at all times. Linens and blankets are furnished for each bed, but the student is encouraged to provide attractive curtains, drapes, bedspreads, and throw rugs for her own room.

Hours of Duty – during the first six months, the major portion of the student's time is spent in the classroom. At the end of the first two-three months of this period when the student has learned to perform some of the simpler nursing procedures, she is assigned to the floors of the hospital. During this preliminary period of six months, classroom and ward duty does not exceed eight hours per day. At the end of six months when the student is fully admitted to the student body, she is on forty-eight hours per week. Classes are attended within this forty-eight period. Inasmuch as the student accepts a definite responsibility for the care of patients in the hospital, she is expected to meet emergencies even though in so doing her regular schedule may have to be modified. For several months after admission, the student is free on Saturday afternoons and Sunday. On one day each week the student is not required to report for hospital duty and may use the day as she sees fit.

Vacations – during the first and second years the student is given three weeks vacation. Seniors are given two weeks vacation. This time is exclusive of holidays unless your vacation falls on a holiday.

Health Service – good health is an essential asset to the successful nurse. The supervision of the student's health is under the direction of members of the medical staff and the Supervisor of Student Health. Upon admission to the School, a general health examination, including X-ray of the chest, and laboratory test is made of each student. A monthly record of weight is kept and additional examinations are made when indicated. Immunization against smallpox, typhoid fever, and diphtheria are required for the protection of the student.

All students when ill are cared for by the hospital for a reasonable length of time. When special nursing is required, the expense must be borne by the family of the student. It is expected that students will care for their own dentistry and will meet the cost of glasses, et cetera, when prescribed. A total of two weeks illness allowance is made during the three years. All of the time lost from illness that amounts to more than two weeks is to be made up at the end of the course. Students are not privileged to be absent from the School to care for sick relatives or for other personal reasons, except in the most extreme circumstances. If such an absence is prolonged, the student's place in the School may be questioned. All such time lost must be made up at the end of the course.

Student Activities – the School is non-sectarian, and the students are encouraged to attend church of their choice. There are churches of all denominations within the neighborhood of the School and ample opportunity is given for the student to make church affiliations and attend regularly.

Each period of advancement in the student's career is celebrated in some way by the staff and student body. The capping ceremony, which takes place when the student is fully accepted into the School, is followed by a reception for the students, their families, and friends. The graduation exercises are followed by a reception, and the juniors and Alumnae honor the seniors with formal parties or teas. Various forms of recreation within the student body mark holidays, and each organization plans its own form of entertainment at other times during the year.

Program of Instruction and System of Grading – at the end of 3 years, the students will receive a Diploma from Park View Hospital School of Nursing. Each graduate ofParkViewHospital may apply for registration as a registered nurse by examination. The North Carolina Board of Nurses Registration and Nursing Education shall give this examination once each year. The grading system has been organized to emphasize both the quality and quantity of professional achievement and is as follows:

Grade of A – Exceptional student. She has mastered the subject matter, thought it through, has seen its relations and meanings as part of an organized whole. Her work shows that she is capable of specializing in this field.

Grade of B – Good student. She has a more thorough grasp of the subject that the C. student. She can either reproduce the materials of the course accurately or reproduce them with a high degree of thoroughness and understanding.

Grade of C – Average student. She understands the minimum essentials of the course well enough to reproduce them upon request.

Grade of D – Poor student. She is below average in the comprehension and understanding of the minimum essentials of the course, but is not so poor as to merit a grade of failure.

Grade of E – Conditioned student. She has failed by a narrow margin, but has the possibility of raising this grade after a few weeks of thorough study.

Grade of F – Failing student. She has failed either through lack of ability or lack of effort, or both, to justify credit for the work done in the course.

Grade of I – Incomplete work of the student. She has been delayed in completing some part of the required work of the course. When this is completed, she may receive any grade from A to F.

Recommendations for graduation are based upon satisfactory completion of requirements and also upon evidence of personal qualifications, which indicate promise of professional growth and reveal characteristics essential to a professional nurse. Diplomas cannot be conferred until the student had met all educational and financial obligations.

The course of instruction covers a period of three years. The first six months is a period of observation and study. During this time, practice is given in the Medical and Surgical departments in order to help the student apply those principles she has learned in the classroom, and is correlated with the studies under the careful supervision of the Nursing Arts Instructor. This period is to test the student's adaptability for nursing work. At the end of six months, those students who have met the minimum requirements in regard to class work, practical efficiency, and general conduct are officially accepted into the student body.

Dismissal – those students who do not meet the minimum requirements of the pre clinical period may be advised to resign from the school at any time during this period or at its close. The Director of Nurses with the approval of the Nursing School Committee may at any subsequent time terminate the student's connection with the school for misconduct, inefficiency, or failure to show qualities essential to the successful nurse.

The Curriculum

First Year: First Semester

Anatomy and Physiology – 120 hours

Nursing Arts – 100 hours

Chemistry – 60 hours

Nutrition – 45 hours

Diet Therapy – 15 hours

Pharmacology I – 20 hours

Elementary Pathology – 30 hours

Psychology – 30 hours

Professional Adjustments I – 15 hours

First Year: Second Semester

Microbiology – 45 hours

Nursing Arts

Advanced – 55 hours

Nursing in

General Medicine – 20 hours

Nursing in

General Surgery – 60 hours

Operating Room Technique

(Including 20 hours of clinical

instruction) – 30 hours

Pharmacology II – 30 hours

Second Year: First Semester

Nursing in General Medicine – 30 hours

Nursing in Surgical Specialties –

Gynecology – 20 hours

Urology – 10 hours

Obstetric Nursing – 30 hours

Second Year: Second Semester

Nursing in Medical Specialties

Communicable – 15 hours

Dermatology – 6 hours

Eye, Ear, Nose, and Throat – 10 hours

History of Nursing – 10 hours

Sociology – 20 hours

Nursing in Surgical Specialty

Oral Surgery – 6 hours

Planned Clinical Experience

Pre-clinical Period – 24 weeks

Diet Kitchen – 4 – 6 weeks

Medical Nursing – 30 weeks

Surgical Nursing – 30 weeks

Operating Room – 8 weeks

Pediatric Nursing – 12 weeks

Obstetrical Nursing – 12 weeks

Vacation – 8 weeks

Psychiatric Affiliation – 12 weeks

Sick Leave – 2 weeks

Lecturers

1955 - 1956

Allergy and Dermatology…………………..Stephen F. Horne, M.D.

Chemistry……………………………… Margaret Cleetwood, B.S.

Communicable Diseases…………………………Lewis Thorp, M.D.

Dental Surgery…………………………..Charles D. Eatman, D.D.S.

Diet Therapy……………………………………Rosa Boseman, B.S.

Diseases of Eye, Ear, Nose, and Throat…………Lewis Thorp, M.D.

Gynecology……………………………….MargaretW. Battle, M.D.

Materia Medica……………………………..John J. Gerlinger, Ph.G.

Medicine……………………………………….John G. Smith, M.D.

Microbiology……………………………………May Belle Chipley

Nutrition and Cookery…………………...Margaret Cleetwood, B.S.

Obstetrics………………………………..Julian C. Brantly, Jr., M.D.

Orthopedics……………………………..…Newsom P. Battle, M.D.

Pathology…………………………………..John H. Frieerson, M.D.

Prof. Adj. I and II…………………………..Verna J. Hartman, R.N.

Pharmacology…………………………….John R. Chambliss, M.D.

Psychology………………………………Claiborne T. Smith, M.D.

Sociology…………………………………..Verna J. Hartman, R.N.

Surgery………………………………………………….(not listed)

Urology…………………………………William J. Frohbose, M.D.

Faculty of theParkViewSchoolof Nursing – 1955 – 1956

Phillis Casper, R.N………………….Supervisor, Colored Hospital

Patricia Dowdy, B.S., R.N……………………..Clinical Instructor

Jean Floyd, R.N…………….Supervisor, Department of Obstetrics

Verna Jane Hartman, R.N…………………..Director of Education

Marguerite Howell, R.N…………………..Nursing Arts Instructor

Mildred Morris, R.N…………………………Supervisor of Annex

Margie Moss, R.N…………………………Supervisor of 2nd Floor

Lillie Weaver, R.N…………………………Supervisor of 3rd Floor

DorisWeeks, R.N……………………Supervisor, Operating Room

Anne Zimmerman, R.N………………………….Night Supervisor

Oral Interview with 1951 Park View School of Nursing graduate Frances Batchelor

I went in training in September of '51 and graduated in September, in fact September 10, 1954. I didn't think anything about it then, because I didn't know any better. But, of course, in later years, I looked back and think about it, it is a wonder we didn't kill folks instead of helping them because we did things like all of our narcotics where in little tiny pills. We would take the pill and put it in a syringe and draw up boiled water out of a spoon that had been heated to the boiling point. And shake that little tablet and dissolve it. And then give it to them.

Well, back in my training days we had to wear stiff starched uniforms. The collars would rub your neck raw, but you still had to wear them. We had a blue uniform with white cuffs and collar, and we wore the white apron over on top. But it was all stiff, starched and you learned how when you were going to sit down, take your apron from behind and fold it over in your lap so it wouldn't get wrinkled. They would literally stand up by themselves. They were so starched and stiff. And you can imagine how comfortable they were to wear. Some of the girls had to put Kleenex in the neck of their uniform to keep it from rubbing so raw. Cause you'd literally get red streaks around your neck from it.

Your freshman year you didn't do anything much but go to class. As we learned procedures, for instance, taking temperatures, we would practice on each other in the classroom, and then we would go across the street to the hospital and take temperatures of the actual patients. Of course, we were watched to make sure we knew what we were doing. And then as we learned the different procedures, if we could, we practiced on each other. Like giving hypodermics, for instance. We practiced on an orange to start with because going through the orange peeling feels sort of like going through the skin. We practiced on that first, and then we gave

each other a shot of sterile water. Our first year was mainly in the classroom. Our junior year we spent more time over in the hospital, and our senior year was practically all in the hospital. We had a few classes our senior year, but most of our time was spent in the hospital working.

When I was a freshman, I was scared to death of Dr. Battle. I soon learned that his bark was a whole lot worse than his bite. But I was very afraid of him. In fact, when I was on the floor and I saw him coming down the hall, if I could, I'd go in another patient's room where I knew he wouldn't be going.

As students, for our pediatrics, we affiliated 3 months atBabiesHospital, a mile off ofWrightsvilleBeach. We got some real experience with babies there, because babies with all kinds of conditions were carried there, some made it and some didn't. But, we got quite a bit of experience there. And then, we affiliated to psychiatry inRockvilleMarylandin a private hospital, delicious food, oh boy! Homemade ice cream every Sunday, oh I mean it was good – eat all you want. At this psychiatric hospital they treated with psychotherapy, which is where the doctors and nurses use talking and medicine together. They didn't do electric shock like some of the other hospitals. When we got toMaryland, we had to first go to where we were assigned to live. There were great big cement porches on the ends of each of the hospital floors and around the porches was real heavy wire. Some of the patients were out there shaking the wire, and I thought "oh oh, I have come to the wrong place now." We were going on duty the next morning, and they told us to not turn our backs on any of the patients. It was explained to us that when one group of nursing students leaves, and when another group comes, the patients get kind of agitated because they don't know what to expect. So I was very particular about not turning my back on any of my patients. One day, this patient walked up and just grabbed my arm. There was a male attendant there, and he was very vigilant, because he knew how the patients were. He walked over and took her arm off of me, and later told me that this particular patient would pick one out of each group that she thought she liked. Grabbing my arm was her way of showing me that, but she liked to scared me to death.

Oral Interview with 1957ParkViewSchoolof Nursing graduate Eva King

The doctors pretty much stayed at the hospital and were close by when we needed them. Usually the doctors would take turns being off one month a year. Sometimes we would work the night shift and then go to class in the morning. At times we would work split shifts in the Operating Room, so you may work7 am to 11 amor3 pm to 7 pm. There was a lot of "hands-on experience." The doctors and nursing instructors taught in the classroom and we went to the hospital to staff. Each rotation such as surgery and obstetrics was 3 months.

ParkViewHospitalcleaned and pressed our uniforms. Our hair had to be off our collar and we could not be married. I played softball for Park View between classes and staffing. When working in the operating room, sometimes the student nurse would have to stand for 8 hours without a break. Someone would bring the surgeons orange juice, but would bring nothing for the student. We stood up when the doctor walked into a room. When a new nurse made a mistake, one doctor was known for saying, "She's not house broken yet."

During my obstetrical rotation I saw ether being used, which was given by the registered nurse. The ether was dripped onto a mask that covered the patient's face. During my psychiatric rotation, I saw shock treatments. I remember making saline by adding salt tablets to water, and there being no running water in the patient rooms. We were required to take care of probably 25 patients, and we had nursing assistants to help us.

We had very little infection back then. I remembered when we had to get glass out of a wound; we would use cotton with peroxide. After graduation I remember gasoline being 25 cent per gallon and I made $200.00 per month.

Oral Interview with 1958 Park View School of Nursing graduate and former Park View Nursing Administrator Connie Merritt Gorham

I graduated from Park View Hospital School of Nursing in 1958. I began work atParkViewHospital in 1958 as a staff nurse in the OB-Gyn department. I worked in this position for six years and then stayed out of work after having a baby. In 1965, I returned to Park View HospitalNursing Administration as an assistant to the Director of Nursing. I remained in that position until the hospital closed andNashGeneralHospital was opened in May of 1971.

Nursing administration's focus and role in the late 1950s, 60s, and 70s was strictly patient care in a narrow scope. There was very little interaction with other members of administration or the medical staff. Hospital organizational structure as well as nursing organization was loose and never a forum for establishing and accomplishing goals. There was no knowledge in the past of nursing administration relative to financial status of the hospital.

Nursing care was based on medical orders. It worked well, as the complexity and technology of care had not yet surfaced. The creation of a four beds for "heart monitoring", spearheaded by Dr. J. Smith occurred atParkViewHospitalin the late 1960s. This was real technology!

Our education atParkViewHospitalwas hospital based and the faculty consisted mostly of physicians offering lectures. The clinical hours were by far the majority and a major part of the education of the nurse. The role of the nurse, both student and staff nurse to the physician was subservient. There was no collegial relationship. Nurses were expected to stand up, offer your seat, etc when physicians came "on rounds." There was never any sharing of patient information.

Mrs. Gorham was also the OB-Gyn Nurse Manager, Director of Nursing, and Vice President of Nursing atNashGeneralHospital. She spent a total of 39 years in nursing practice, of which, 33 years was in leadership positions.

Oral Interview with 1958 Park View School of Nursing graduate and former Park View Nursing Instructor Ennis Lucas Edwards

I graduated fromParkViewHospitalin 1958. We started with 26 in our class and we graduated with 17. I began teaching in 1960, and I taught for nine years at Park View School of Nurses.

It was very difficult to get a college degree after graduation from Park View. This was due to there be very few universities that offered a nursing program. UNC-Chapel Hill and Duke were the only ones; ECU did not have a program at that time.

The class instruction at Park View would vary, anywhere from one to 3 hours per day in the freshman year. The juniors and seniors were usually in class around four hours a day. Classes may end at3 pmand then the student would have to work3 pm to 11 pmor11 pm to 7 amin the hospital. When the students worked these shifts it was without a nursing instructor.

We did not have the nursing process (assessment, planning, intervention, implementation, evaluation), but we were starting to develop and use care plans. They were on one card that was double-sided. Our theory component consisted mainly of the body systems, such as Respiratory, Cardiac, Urology, etc, and we taught courses specific to the specialties such as Medical/Surgical, Psychiatry, and OB/Pediatrics. For the psychiatric rotation, our students went to theStateHospitalfor three months, and for pediatrics, they went to Baby's Hospital inWilmington. However, when the North Carolina State Board of Nursing became more involved at Park View, the pediatric rotations were done atParkViewHospital. We had specific instructors for specialties such as Chemistry, Pharmacology, and Nutrition. A pharmacist taught our pharmacology course. We taught only nursing and science courses, there were no pre-liberal art courses.

We did use visual aids and we borrowed films from NC catalogs,EmoryUniversityinAtlanta, andBaylorUniversity. We did have a lab, which we used for Fundamentals of Nursing. Here the students practiced bed making, vital signs, etc. The students learned how to give injections on an orange and then they practiced on each other. Nasogastric tube insertion was taught in the senior year, and the students used manikins to practice nasogastric tubes and catheterizations.

No physical assessment skills were taught, such as assessing heart and lung sounds. The students were taught to never question a doctor or his orders. The nursing instructors would perform room and uniform inspections.

There was no review course for the state licensure exam; however, it was strongly suggested that the students buy a review book. During the last few years of Park View School of Nursing, the school had a 100% passing rate on the state board exam.

You began to see some changes in nursing in the late 1960s. Due to the North Carolina State Board requirements, classes at Park View were beginning to be planned around staffing. In other words, if a student nurse worked11 pm to 7 am, there would be no class for that student. Also, around 1969 students were taught to professionally question a doctor's order if they had a question concerning the order.

AfterParkViewHospitalclosed in 1969, Mrs. Edwards taught the nursing assistant and LPN program atNashTechnicalCollege.

Demerit System atParkViewSchoolof Nursing

While attending Park View School of Nursing, student nurses were required to follow certain rules and policies. If these rules where not adhered to, the student nurse could receive a demerit. Each demerit would represent certain points. After 10 demerits a student nurse would be called before the Park View Nursing

Council to be evaluated according to her demerits. Certain demerits or certain number of demerits could result in the student nurse not be allowed to leave the campus for 7 days. This was referred to as being "campused". Usually being campused included no television, radio, mail, or visitors. The following is taken from a 1964 Student-Faculty Cooperative Government Association of Park View School of Nursing (pgs. 5 – 8), which describes actions that could result in demerits.

(Nurses Residence), ONE DEMERIT: excessive noise in rooms, eating in the living room, food not in a closed canister in room, any electrical appliance other than those stated in regulations, hanging a picture or driving nails without permission from the housemother, failing to put name on the door, leaving lights and radios on in empty rooms, unmade beds, out of room after 10:30 pm, lights and radios not off by 11:00 pm, bedroom and bathroom doors not closed when a student is disrobed, spending the night in another student's room without permission from housemother, radios turned on before 9:00 am, an overnight guest without permission from the Nursing office. **TWO DEMERITS:** dirty or untidy rooms, students leaving nurses residence before 7:00 am or after 9:00 pm., smoking in areas other than those stated in regulations. **THREE DEMERITS:** leaving any outside door unlocked after it has been locked by the housemother, using the side and back door of the Nurses Home after 5:00 pm. **TEN DEMERITS:** drinking of alcoholic beverages and/or disorderly conduct, this could be grounds for expulsion.

(Hospital), ONE DEMERIT: going to nurses residence or leaving the hall while on duty without permission from the head nurse, duty hours changed without permission from the Director of Nursing or her assistant, visiting in hospital other than as stated in the Regulations, students receiving or making personal telephone calls while on duty, students on 3 – 11 pm duty are to be in the nurses residence by 11:40 pm, dates are not allowed to walk with students to work, students using charts in hospital without uniforms. **TWO DEMERITS**: students on call to the O.R. are not to leave the nurses residence except to go to Thompson's Pharmacy, students leaving campus or seeing visitors after coming off duty at11:00 pm.

(Assembly), ONE DEMERIT: failing to put name on spindle in the secretary's room when missing Assembly on days off, failing to get an excuse from head nurse if unable to attend when on duty.

(Uniforms and Linen), ONE DEMERIT: not changing linen as stated in regulations, not placing soiled uniforms in laundry cart as stated in regulations, not picking up clean uniforms as stated in regulation, ironing in areas other than laundry room, washing or ironing on Sunday. **TWO DEMERITS**: not attending Assembly as stated in regulations.

(Signing Out), improper signing out, one student signing out for another, signing in before visitors dismissed, students while working failing to check time sheet as stated in regulations.

(Overnight Privileges) TWO DEMERITS: Students leaving residence after9:00 pm. (may be brought before Faculty).

(Dating), ONE DEMERIT: students sitting in parked cars around nurses residence or hospital, not setting watch by clock in living room, failing to call the housemother or a student Council member if an emergency necessitates a student being late. **FIVE DEMERITS**: failing to call the housemother or a student Council member is an emergency necessitates a student being late.

(Vehicle Privileges), TWO DEMERITS: if having or operating an automobile other than as stated in the regulations.

(Dress regulations), ONE DEMERIT: wearing long pants or shorts other than as stated in the regulations, wearing improper street clothes or incomplete uniform to class or dining room, wearing socks other than as stated in regulations, not wearing proper wraps in cold weather.

(Uniform regulations), ONE DEMERIT: not adhering to each uniform regulation as stated in Handbook. **TWO DEMERITS**: being in cars in uniform except as stated in regulations, talking to visitors in cars while in uniform, going to public library or park wearing nursing cap, chewing gum while in uniform.

(Closed Study), TWO DEMERITS: making or receiving telephone calls. **THREE DEMERITS:** out of room during study hour, playing radios, or loud talking.

(Library Regulations), ONE DEMERIT: removing reference books, encyclopedias, and dictionaries from the school library, failing to sign library books in or out, failing to sign in to study. **FOUR DEMERITS**: going out if unable to go on duty or attend class.

(Health Regulations), ONE DEMERIT: failing to report illness as stated in regulations, failing to abide by regulations for visiting,

(Eating), ONE DEMERIT: bringing food to students' not ill, leaving glasses or dishes in bathroom or showers.

Oral Interview with 1967ParkViewSchoolof Nursing graduate Louise Wehrum Carmichael

In the 1950s when I was in the eighth grade we had career day and everybody had to decide what he or she wanted to be. I wanted to be an airline stewardess, and in the dark ages, you had to be a nurse first. So, my entire curriculum was headed toward being a nurse.

I enteredParkViewNursingSchoolAugust 31, 1964. When I came toRocky Mount, this is during the time the Vietnam War had just started up, President Kennedy had been killed the previous November, and the civil rights movement was gearing up.

There are two things I remember from my orientation at Park View. One of the Park View personnel got up and said if we ever thought we had any value to the hospital, we should put our hand in a bucket of water and pull it out. The impression we left in the bucket was our importance to the hospital. Then, another nursing instructor said that you didn't learn until you were frustrated, and you weren't frustrated unless you cry. She then stated she intended to see every one of us in tears before we left her.

Let me tell you about the operating room. Back then in the operating room, the RNs were the first assistants, the OR techs circulated the rooms, and the student nurses worked the sutures or the instrument table. Most of the time I was the suture nurse. We had some of the most horrendous accidents you can imagine. The Vietnam War was kicking up, so the military bases were loaded. When the military guys were on a weekend pass, they couldn't go more than, I think, 150 miles from the base, and they had to be back at a certain time. But they wanted to go home, so sometimes they went as far as up asRochester,New York. So, on Sunday nights they'd be racing down the road trying to get back to the military base on time, and they would usually hit a fatigue level when they got toRocky Mount. This is where we got some of our worst accidents.

We had Stony Creek ambulance service, but most of the ambulance services were actually the hearses from Johnson and Stokes' mortuary. When they brought the accident victims in, if they were in really bad shape, we basically triaged, stabilized them, and transferred them to Duke orChapel Hill. Sometimes, especially when they were really bad, a student nurse would ride with them in the ambulances to Duke orChapel Hill.

Dr. J. Dr.Battlewould make you count the stitches. So, at the end of the case he'd say, "How many stitches?" and you'd better know because he was counting too. Dr. Frohbose use to say, "Don't give what I ask for, give me what I need." So, when he put his hand out, you had to know. Dr. Brantley, Jr would quiz us during the surgery. Sometimes he wanted to know the names of all the great lakes. I remember one day he asked the difference between an optimist, optometrist, and an ophthalmologist. I remember sometimes in the operating room our hands would get popped, the doctors would through stuff, scream, curse, and call us idiots.

During the operating room rotation, one of the things the student nurses were required to do was be the retractor holders. Students would have to hold retraction for hours. Your hands would get numb, the pain would go up your arm and down your shoulders, and there would be no feeling in them for hours. And, if you let go of the retractor, you couldn't get your fingers back on. I remember doing a hip with Dr. Battle and the field was bloody. We were in there so long that the blood dried and it began to flake.

When you were on call for the OR, you worked was called the split shift. You went in at7 amand got off at11am. You came back at3 pmand worked until7 pm. Then you were on call from7pmuntil7am. There were no pagers, so you had to be by a telephone, you couldn't go anywhere. If you got called out during the night, you were still posted to work7 am to 3 pmthe next day.

We didn't have disposable gloves, so the student nurses would wash them out. There was a big box up near the window and after the gloves were washed, we would dry them on racks. When one side was dry, you would flip them to dry the other side. The gloves were then thrown into the glove box that had powder. Next, you would stick your hands in the box and powder the gloves. We learned how to fill them with air and pop them out. You would then pair them up left and right. You would put the gloves on a special paper and then send them to be autoclaved.

The anesthetic gasses that we used were so explosive that all the chairs and equipment had chains for static. We had to wear rubber inserts in our shoes and cotton underwear so we wouldn't have static. We made all of our saline solutions. To make the saline, you would go to the distiller and you would fill glass flasks to a certain level. You would then add, I believe, 7 sodium chloride tablets. You would then cap the flasks and send them down to be autoclaved.

As far as our training, I remember we had to give each other bed baths, and we had to make sure we kept the body parts covered appropriately. When we learned to give injections, we gave each other saline injections. We practiced on our roommates, so we made sure everybody knew what they were doing before we let the needles come. After we made the beds, you could bounce a quarter off them. I remember Louise Carrington used to say if she could bounce a quarter off our bed, we could keep it. Well back then, a quarter would buy you two and half Cokes.

Back then, the doctors didn't have any pagers, so there was a bell, and each doctor had a code. The student nurses and nurses had to learn the codes for the doctors. It could be three dings, two dings, or a ding and a pause, and then three dings, etc.

Sometimes I would work3 pm to 11 pm, go back to the dorm, get back up at five in the morning, get dressed, straighten up my room, get my books together, and be back on the floor at6:45 am. You would then work until3:15 pm, and there could be a class in the afternoon. The other thing that might happen is if you worked7 am to 3 pmand the3 to 11registered nurse called in sick, you did a double shift.

Some of my classmates couldn't make the grade and some couldn't take the pressure. Park View told us when we could eat, when we could sleep, when we could go out, and how to dress. We weren't allowed to wear slacks, shorts, or socks. We always had to have on hose. If you went out of the building, you had to wear high heels. Your uniform and coat always had to be pristine. There were several things you could receive demerits for, such as not having your hair off your collar, moving the furniture in your room, if your bedspread wasn't straight or if your shoes weren't white enough. You could also be what was called "campused." If you were campused, the only time you could leave your room was for classes and meals. Campused meant no radio, no television, no mail, and no telephone calls. It was complete isolation for that week.

One of the things I remember the most was when they announcedParkViewNursingSchool was going to close. In March of 1967, hospital administrator Lyman Melvin and one of the nursing instructors called a meeting that included all the nursing instructors and students from all three classes. The meeting was held in the basement of the nurses' dorm. They stated at the end of the summer session with the class that was graduating, the school would be closed, and this was my class. After that was announced, nothing else was said, and they walked out. There were no efforts or anything done; there were no arrangements for the freshmen and juniors. There had been a class already accepted, so the class of 1968 and 1969 had to fend for themselves, and the class of 1970, never came.

Everybody was upset; the whole place was just in tears. So we went and said we have to do something. A nursing instructor named Donnie Brooks, two freshmen, and me got a piece of carpet runner and with shoe polish wrote, "Please Don't Abandon Us" on the carpet runner. We crawled out on our hands and knees out onto the balcony of the nursing dorm and we put the sign out on the front of the balcony so everyone could see. While we did this, nursing instructor Brooks was watching the hall.

Our sign hung there probably four to five hours and during that time, someone called the newspaper to say it was out there. When the administration at Park View saw it, the coo-coo hit the blaze. They called everyone back in and wanted to know who did it. Well, Donnie Brooks and I knew if they gave us up, she was fired and I was out. I mean there was no question about it. And do you know, nobody gave us up. That secret was kept for about 20 years.

Well, there was an article in the paper about the protest, and within the next week, there were all kinds of editorials that showed up in the paper. There was one from Dr. C.T. Smith and from other members of the community stressing the importance of keeping the school open and letting the class of 1968 and 1969 finish their education. Based on everything that happened,ParkViewNursingSchooldid remain open until 1969, and the class 1968 and 1969 did graduate on time.

Oral Interview with 1968ParkViewSchoolof Nursing graduate Joanne Guyant Brake

The first six months of our training was known as the "probation" period. We did very little clinical during this time, we mainly attended classes. After our six-month probation period was over, we were capped and started staffing the hospital. During the summer of my first year, we were working in the hospital under the

supervision of a junior or senior nursing student. The clinical instructors were not with the nursing students after they were checked off on a procedure.

When you were a probationer, you had to be in your room at8 pmand study until10 pm. This was called closed study. When you were junior, if you were not working, you could go out on Friday or Saturday night, but you had to back in the dorm at10 pm. The juniors still had closed study during the week from8 pmto10 pm. The only time you missed closed study is if you were working. The senior nursing students were not required to have closed study and they could stay out until11 pmon Friday or Saturday.

We had a housemother and she knew where we were at all times. When you left the dorm, you had to sign out in a book the time you left, and when you returned, you had to sign back in. You always had to make sure you put the time in correctly by putting if it was am or pm. Sometimes, you could receive demerits if you didn't sign the book correctly. If a student had a date, she had to let the housemother know where she was going.

We were not allowed to have a car, and we could not wear make-up, perfume, jewelry, and our hair always had to be off our collar. You couldn't even wear make-up if you went out on a date; however, you were allowed to wear your hair down if you went out on a date.

My entire tuition was $300.00. This included all classes, uniforms, books, meal, medical care, and room/board. We could receive $1.00 per hour if we worked an extra shift.

Today of course, we have universal precautions, but when I was at Park View, the only time we wore gloves was during a sterile procedure. We didn't wear gloves to empty someone's bedpan. We didn't even wear gloves when we changed a dressing unless it was a sterile dressing. We never threw our gloves away. We would put water in them to check for holes. If they leaked, you patched them. Actually, we hardly threw anything away. We reused our needles and we had glass syringes. The student nurses would have to check the needles for spurs by rubbing a cotton ball over them. If there were any rough edges, you would have to take an emery or sandpaper and file them down.

We got one weekend off a month, but that wasn't guaranteed. If someone called in sick, or they needed someone in the operating room, then you had to work on your weekend off. You had no choice.

The doctors treated us like third class citizens. We had to stand up when they appeared, and we were at their beck and call. You made rounds with them, you did all their writing, and you wrote their orders while they rattled them off. Basically, you were their handmaidens. Sometimes, they would walk past you in the hall and not acknowledge you were there. If you were at the bottom of the stairs and a physician was coming down the stairs, you had to wait until he was off the stairs. Some doctors would scream, cuss, and belittle you. However, there were doctors that treated us very nice.

During Joanne Brake's nursing career, she worked at the Edgecombe County Health Department, in an extended care facility, and on a medical floor. She also worked for Dr. Sheridan for six years, and for Dr. Crocker for two years. She completed her career by working for Rocky Mount Urology for nine years, and she taught nursing assistant classes atEdgecombeCommunity Collegefor eight years.

Oral Interview with Park View physician, Dr. Lewis Thorp

When I arrived at Park View, I found a Diploma School of Nursing in full flourish headed by a Ms. Claiborne. Ms. Claiborne was a marvelous top sergeant of a director, tough as nails, but an exquisitely good nurse, and she demanded that of her students. The classes, there were three of them, had about 15 students in each, and of course they were all women. Dr. C.T. Smith liked to say they were mostly farm girls who had come to town to get an acceptable education, which was somewhat shorter and easier to obtain than teaching, those two being about the only thing women could train for in those days. Nursing was an acceptable profession, but was not done by the daughters of the carriage folks, the rich folks, it was mostly as Dr. C.T. Smith said girls from the farms. These nursing students had the attribute of having lived with nature and having seen birth and deaths of animals, injuries, and things of that sort, which fitted them remarkably well.

The nursing students were taught by the doctors on the staff, and I was immediately assigned a bunch of classes which I found to be a lot of fun because these girls were like blotters; you were looking at about four rows of wide opened faces that absorbed everything you said, and tended to be very intense with their studies, and it had an advantage for us that we taught them our way of doing things. Park View would put them on their own rather quickly after a year. A girl might find herself on third floor, which was a busy medical floor, at night by herself, and that's where the buck stopped. She had to make the decisions.

The high schools these girls came out of were not all that great, most of them rural schools with their mastery of spelling, English, and math lacking, sometimes, but not all times. I remember reading one of the student's charting and she had a problem spelling "quiet" and she spelled it "quite", so her charting stated it was "quite a night", and it probably was. Another student nurse called to report a BUN of 320, and that would have killed somebody. When I asked her was she sure, she said, "Yes, there is a period in the middle between the two 00's, and so, the BUN was really 30.

These girls wore very handsome blue and white uniforms. The white being an apron type apparatus, and caps they received when after they had completed their probation period. They also received a wool cape, which served as an overcoat in the winter. It was a very handsome uniform, they looked great. There was none of this business of running around in slacks and T-shirts, and they had a special nurse's shoe, no tennis shoes

The student nurses couldn't marry while they were in the school, some of them forgot that, but they just couldn't tell anybody. They really didn't have much social life. The nurse's home, the place they lived, which was across the street from the hospital, had a dormitory type arrangement, which was about two steps short of a Marine Corp boot camp. It was very clean, very precise as to time of meals, type of dress, and conduct. That didn't keep them from having a good time, as you can't suppress a bunch of young women like that. They had a lot of laughs, and in retrospect, when they meet, they have a lot of great memories of that school, but it was hard.

In response to this, they became the best nurses I have ever encountered. A Park View graduate is given to be an excellent nurse, and a lot of them ended up in leadership roles in their profession. One was in charge of obstetrics atNorth CarolinaMemorialHospital, one was in charge of all of the medical care in the world out atOcracokeIsland, that was Kathleen Bragg, and one was in charge of Emergency Services atRexHospitalinRaleigh. They were good nurses.

When asked what I think nurses need to know in 40 or 50 years, I'll guarantee you that it will be something different than they know now. Well over half of what I learned in medical school was wrong. I found a set of notes the other day to confirm this. Well over half of what is being taught today is wrong and we don't know which half. So, in 40 to 50 years from now provided the economy will maintain the cost of all this

hardware, we are going to have seen enormous changes in medical care, and probably continued longer life, unless somebody pushes a button on one of these mass destruction deals before then.

Summary

This chapter presented a brief history of Rocky Mount, North Carolina, the history of Medicine in Nash County, and an in depth historical look at the history of Park View Hospital and nursing education at Park View School of Nursing. Research was obtained through oral interviews with ten former nursing graduates, including a former nursing instructor and nursing administrator from Park View School of Nursing. Also, a previous Park View physician who taught in the nursing program at Park View was interviewed. These participants provided an invaluable story about the history ofParkViewHospital and Park View School of Nursing.

In addition to oral interviews, the research includes detailed information obtained from newspaper articles, history books,ParkViewHospitalbrochures, and actual Park View School of Nursing curriculum documents. Historical events surrounding Park View were also discussed including the Spanish Flu Epidemic, World War I and II, and implementation of the Cadet Nurse Corp. The methods used in this research have provided a historical look atParkViewHospitaland Park View School of Nursing from the day it opened in 1914, until the day it closed in 1971.