NAMING POWER: A HISTORICAL ANALYSIS OF CLINICAL INFORMATION SYSTEMS, 1970-1990

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ABSTRACT


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This dissertation examined the historical development of nursing clinical information systems (CIS) in healthcare during the late twentieth century. CIS were recast as a contextually bound technological system of skills, tools, and knowledge needed to provide patient care. This recasting provided for consideration of the historical and contemporary meanings of these systems and challenged pervasive assumptions about their structure. Three tools, the Classification of Nursing Diagnosis, the American Nurses’ Association Social Policy Statement, and the Nursing Minimum Data Set, were analyzed to gain an understanding of how nurses prioritized certain types of information, skills, and knowledge, while excluding others. Primary source material from individual nurses and nursing organizations that were involved with the creation of CIS were used. The process of identifying information to be included in CIS was contentious. Individual nurses who argued on behalf of a particular piece of data or form of data, did so because of a strong belief in how nursing practice (through information collection) should be structured. Throughout the historical cases, participants paid little attention to existing practice conditions that would ultimately determine whether or not the CIS would be used. Time and time again, the composition of the group determined for whom the information practice would be most useful and where the information practice would
likely be applied. The development of CIS illustrated the political nature of practice,
the importance of including the perspectives of those who do the work of CIS, and how,
when existing conditions are ignored, CIS can fail.
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Prologue

Clinical Information Systems and the Problem of Information

"If you cannot name it, you cannot control it, finance it, research it, teach it, or put it into public policy."

Norma Lang

Information as Panacea

In 1985, a group of nurse administrators and faculty from across the country met to identify and develop a Nursing Minimum Data Set (NMDS). The group intended the data set to function in two distinct ways: to provide practicing nurses with information needed to make effective decisions about patient care, and to give administrators and researchers the means for evaluating the care delivered. This was a tall order made more difficult by the group-selected application and use of the NMDS in no less than five settings where nurses practiced: hospitals, ambulatory care, home care, community, and long-term care. This group of nurses, although highly educated and motivated,

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1 The quote was stated during a working session of the small group drafting the plan for the International Classification of Nursing Practice at the International Council of Nursing headquarters in Geneva, Switzerland sometime in 1990. Since that time it has been translated into many languages. It was first published in Norma Lang and June Clark, “Nursing's Next Advance: An International Classification for Nursing Practice,” *International Nursing Review*, 39 no. 4, (1992): 109-112.
2 The definition of a minimum data set, according to the Department of Health and Human Services, is a minimum set of items of information with uniform definitions and categories, concerning a specific aspect or dimension of the health care system which meets the needs of multiple data users within the health care system. Harriet H. Werley and Norma M. Lang, eds., *Identification of the Nursing Minimum Data Set* (New York: Springer Publishing Company, 1988).
3 Initially, the data set was constructed as a paper checklist of data points with uniform definitions. The intent was to later convert the paper form into a software program that could be used in the same manner.
experienced great difficulty in determining what information was the “minimal” amount of data needed to serve all the purposes and processes associated with their goals.

Throughout the preconference planning, conference, and postconference, lively discussions erupted over what information to include in the data set, how to organize it, and perhaps most important, why certain types of information were necessary. Many of the nurses involved with the NMDS staked their careers on how the data set developed, what was in it, and how it might be used.

Nurses involved with the NMDS palpably and ardently believed that if they had more clinical information, they could better understand—and more important, have power over—clinical practice. Using this control, nurses involved with the data set believed they would have the capacity to thwart attempts to dictate the work of nurses from groups like medicine. This group of nurses believed they could use the information contained in the NMDS to facilitate policy changes, gain bureaucratic representation within healthcare organizations, and ultimately help organize the work of nurses. These were logical assumptions about how this information could be applied, but nurses involved with the NMDS failed to deal directly with the political nature of their proposal. In the end, identifying the “it” of what information was useful and to whom proved to be more difficult than anticipated, ultimately rendering the NMDS unworkable.

Certainly, an argument can be made that the main hurdle facing creators of the NMDS was the ambitious, all-encompassing project purpose; however, larger challenges...
faced conference planners and participants. Rapid introduction of new medications, treatments, and life-extending technologies such as cardiopulmonary resuscitation (CPR) were changing patient care requirements and expectations. Patients survived previously life-ending illnesses and anticipated access to whatever new treatments were available. Nurses needed sophisticated skills, tools, and knowledge to implement these new treatments, monitor the effects of new drugs, and safely and effectively care for what was fast becoming a sicker patient population.\(^5\) Acting as a bellwether, nurses across the country began changing their practice in response to these shifts in expectations, in order to provide safe and adequate care. The haphazard adoption of these new skills, tools, and knowledge added to the complexity of these transformations that had more to do with choices by individual nurses than the lack of uniform availability and opportunity.

As practicing nurses began to take on increasingly complex and diverse roles in various clinical settings, those nurses in academic and regulatory circles who were removed from practice had to play a game of catch-up and struggled to comprehend the extent of these changes. Many, including the creators of the NMDS, deliberately chose to define these practice changes as a problem of too little information. They believed that if more information was available, easily accessible, and in specific useable forms, nurses could provide better care, conduct relevant research, and facilitate policy change. Moreover, by identifying and collecting information about nursing practice, nurses would make nursing care a visible entity. The specifics of proposed strategies took numerous forms that included developing standards of practice and certification mechanisms for

\(^5\) Patients who previously died because they presented with untreatable diseases were now being sustained by a variety of newly developed interventions such as medications and cardioversion.
general and specialty practice, changing the scope of practice through regulatory aims, developing classifications for services, and creating MDSs. Regardless of the specific strategy undertaken, information was viewed uniformly as the key to nurses gaining control over these practice changes, harnessing the inherent power associated with defining the issues, and using these changes as a means to further various professional and political agendas.

Given the importance that nurses and others in health care placed on information, examining the development of these information strategies offers a unique vantage point from which to examine the history of nursing, particularly the intersection of nursing and technology. Information strategies, including practices such as the NMDS, were developed to meet specific needs and expectations at particular times and places in the nursing field and can be examined as technological tools reflective of the people, places, and events of their making. While those who developed these practices did so for specific purposes such as billing or evaluating services, the practices also served as examples of highly contested social negotiations about the role of nurses in healthcare organizations, negotiations that occurred during both the development and dissemination of the tools.

**Study Overview**

The present study examines the development of clinical information systems (CIS) in healthcare from 1970 through 1990. A CIS is defined broadly here as a contextually bound technological system of skills, tools, and knowledge needed to provide patient care. This technological system is more than a network of physical

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artifacts or individual information practices; it is a socially constructed system that rests within broader social, cultural, and political contexts.\(^7\) CIS, defined in this way, come to represent how clinical practice is constructed.\(^8\) Further, by defining CIS in this manner, technology can be more fully explored as the underlying political structure of healthcare, and can illustrate the nuanced position of nurses and patients within broader social, cultural, economic, and political contexts.

A CIS encompasses the skills practitioners need to interact with a multitude of individuals and technologies in order to gather information about a specific patient situation. The skills component resides in both social and technical domains, as the practitioner must possess the necessary skills to deploy a particular technology such as a


blood pressure cuff and stethoscope, and the social skills necessary to interact with the patient and communicate information to clinicians and others within the system. The CIS also includes the tools needed to organize information for different purposes. These tools can be paper forms or computer software programs and are generally categorized as either tools used to produce a piece of data about a patient, or tools used to organize that data (it is acknowledged that a technology can do both, but the categorization is intended to describe the primary use of a given tool within this system). The third element of a CIS is knowledge, specifically knowledge needed in a given patient situation to prioritize information effectively; such knowledge makes possible the identification of patient problems. Patient situations are temporal and connected to previous patient situations. These three elements of a CIS comprise a process that prioritizes certain types of information while excluding others, organizes prioritized information into a useable form, promotes accepted standards of information practices, and applies information to a particular patient situation. Moreover, these elements illustrate whether, and how, the work of nurses is shaped by the system. Skills, tools, and knowledge, when examined in this manner, illustrate the process of gathering and organizing information that incorporates the social, political, cultural, and economic contexts. These contexts simultaneously reside within and externally influence this complex system of care.

In the present study, the historical development of nursing information practices associated with patient care are used as the means to examine CIS. Information practices are the compilation of standards, protocols, and patient data forms, as well as other related tools (e.g., systematized interventions for specific diseases; hourly, shift, or daily collection of vital signs; physical examination data; classification schemes; or other
means of (re)configuring patient information). Collectively, these tools make up a set of
established norms that, when taken together, represent the information practices of a
given clinician, group of clinicians, unit, hospital, or profession. These information
practices represent an effort to configure human information into a structure that may
superficially mimic human cognition but is inherently social, political, cultural, and
economic.

Chapter Overviews

By considering CIS to be technological systems that comprise the skills, tools,
and knowledge needed to provide patient care, I was able to analyze information
practices that appear superficially disparate, viewing them as tools residing within one
system. This enabled me to treat the manuscript collections selected for this study as
representations of specific types of information practices, but also provided a means for
organizing the narratives. The narratives are structured into three cases, with an
accompanying introduction, Changing Patients, Changing Practice, that more fully
explores practice changes mentioned above, specifically the introduction of new tools,
skills, and knowledge and the influence these had on existing nursing practice.
Discussion of how nurses found ways to manage these new tools, skills, and knowledge
through information is also addressed. This section begins to illuminate how CIS shaped
patient care and the work of nurses.

Chapter 1 addresses the way in which CIS prioritized, organized, and promoted
certain types of information skills and workers while excluding others. By illustrating
shifts in the public’s perception of physicians and a rise in acknowledgement of patient
decision-making capacity and consumerism, this chapter explicates how these factors
contributed to patients seeking other providers, specifically nurses, for health information. Nurses were uniquely positioned to respond to patient questions and concerns, but at the time, lacked the skills necessary to do so. This change in patient-nurse relations, coupled with treatment changes, shifted expectations about the role of nurses in providing health care. The public expected nurses to know, identify, and discuss their concerns about their illnesses.

We can see how CIS prioritized certain aspects of nursing and physician practice through the identification of patient problems. Nurses were expected to identify "problems" rather than diagnoses; they were expected to discuss and address issues surrounding a patient’s experience of disease, but they could not be the first to identify the disease. So, although nurses were expected to provide care in the form of sophisticated demonstrations of clinical reasoning, this reasoning could not be so explicit or in-depth as to identify a diagnosis.

Chapter 2, *What's in a Name? The Classification of Nursing Diagnosis, 1973–1990*, illustrates further how a patient problem is named in nursing and the contextual factors that influence the naming process. This particular case, as are the other two cases, is illustrative of a particular type of information practice used within CIS. This case demonstrates the development of a classification, the Classification of Nursing Diagnosis (CND), which was initially intended for use by a specific type of nurse, the Nurse Practitioner (NP), practicing in what is now considered an advanced role. This role of the NP emerged during the 1960s and early 1970s in areas across the country, and with it a growing need in some circles to differentiate this type of practice from that of physicians. In this particular case, there were several motives for making this distinction. Some
nurses sought the ability to independently bill for services, teach students this new practice role and, of course, control practice. Nurses involved with the CND believed that they would be able to manage practice by delineating a classification that outlined the problems germane to some nurses. Like any classification system, the language used in the CND to describe nursing practice illustrated significant biases that reinforced the status of nurses in the gendered structure of healthcare. Nurses were expected to care and physicians to cure, but the nurses involved with the CND and others across the country were doing both. How then was this work that straddles both medical and nursing domains to be captured? Labeling elements of the classification using signs and/or symptoms of disease rather than names of diseases was one way nurses involved with creation of the classification avoided overt acknowledgement that NPs were engaging in medical diagnoses. The choice of language gave the CND nurses a way to speak openly about the work they were doing without directly challenging the hierarchy in which they worked.

In chapter 3, Maintaining Relevance: The ANA Social Policy Statement, 1980–1984, we see how one national organization attempted to shape the information practices of the profession of nursing. The American Nurses' Association (ANA) Social Policy Statement (SPS), a statement about nursing's responsibility to the public, put forth a highly contested definition of nursing practice that included a statement about diagnosis. The SPS, like the CND, declared that nurses treat the symptoms, not diagnose disease. This policy statement was in large part a reaction to extensive losses in the organization’s

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prestige and, more important, membership (revenue) during the 1970s and early 1980s, as practice changes shifted member demands at such a high rate that the organization could not keep pace. The ANA was losing membership to emerging specialty organizations poised to meet the needs of very specific sections of ANA’s membership, for example, critical care nurses, nephrology nurses, and oncology nurses, to name a few. These membership blocks comprised both NPs and nurses who worked in areas that required specialized skills and knowledge. As each area of specialization grew, the ANA’s struggle to maintain responsibility over the scope, standards, and certification of nursing practice intensified. The ANA attempted to regain some semblance of relevancy and control in, and over, nursing by means of the SPS and the logical extensions of the statement that included taxonomy development, standards of practice, and certification. The ANA viewed the SPS as the essential information practice for the organization, one that coalesced all its functions into one single document. The SPS delineated what the ANA believed was its rightful role in American nursing—to define what nursing practice is and is not. Repeatedly, bitter exchanges occurred within the ANA over control of these new areas of clinical practice, further weakening the organization, with perhaps the most vitriolic exchange occurring with the 1989 separation of the California Nurses Association from the ANA.

You Say Uniform, I Say Unified: The Nursing Minimum Data Set, 1985–1990, makes up chapter 4 as the third and final case presentation. This case illustrates the issues surrounding control in CIS and how, when shared information practices are ignored, initiatives surrounding changes to these practices can fail. The NMDS is an interesting case, as it represents an information practice that was intended to create an altogether
different record of the patient's service use, one that accounted for the work of nurses. Ultimately though, this case is about how shared initiatives can fail when consensus is neither desired nor sought; it also illustrates the complexity of moving from an entrepreneurial ideal to practical application.

Finally, the epilogue revisits issues addressed within each case and across cases. This summary reviews the problem of information as illustrated in each of the cases, and how that problem relates to present-day CIS. This section also presents a discussion of the ways in which the identified conceptual elements are applied to practice and to our current understandings about CIS. Ending the section is a brief discussion about possible policy applications and future work.

Time Period and Other Works

The late twentieth century offered a unique opportunity to evaluate the development of CIS, primarily because at the time there were numerous changes in these systems that demonstrate how clinicians prioritized patient information. The introduction of computers and software tools, in combination with major regulatory and economic pressures, provide the backdrop to shifts in the way clinicians thought about information, and thus about patients. The specific time period selected for this study, 1970–1990, is of particular importance because it encompasses a period when CIS were amenable to restructuring as many healthcare institutions initiated transitions from paper to computerized record keeping. While this transition from one artifact to another is

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10 A 1975 survey conducted by the American Hospital Association found that, of some 6,000 hospitals, approximately 1,500 had in-house computers. These computers were used for various clinical functions, including lab data management, physician order entry, and general charting regarding patient stays. See Marcia Opp, "The Confidentiality
important, it is important only as much as it was socially meaningful. Nurses, physicians, government agencies, hospitals, professional organizations and the public saw opportunity during this time period to change CIS, thus effectively reprioritizing the information collected about patients. This unique period captures changes in the technical design of the system as well as changes in its social meaning prior to these elements collectively becoming embedded in practice. Moreover, the time period encompasses significant changes in the way people thought about their personal health information, including such issues as access, privacy, and ownership.

Although extensive secondary sources exist that address the contextual background for this study, surprisingly few works address information practices. Additionally, while chronological overviews of the development of computers in nursing...
are numerous, there remains a considerable void in critical historical scholarship examining nursing information practices.\textsuperscript{14, 15} This is perhaps because any study addressing this topic must span boundaries between several diverse bodies of literature, including investigations of patient records, classifications, information science, computer science, public policy, and histories of technology and healthcare. The summation of this diverse body of literature supports the assertions that information is highly political and that specific types of information practices, such as classifications, are representative of the values and beliefs of those who generate such tools. Further, the literature points to the "problem of information" that is scarcely addressed in any scholarly arena. The social


history of technology framework, illustrated above, encompasses this diverse literature and enabled analysis.

**Primary Sources**

The archives selected for this study hold collections related to the development of different types of nursing information practices. The North American Nursing Diagnosis Association (archives located at Boston College) was one of the first organized groups to create a formal classification for nursing. The collection contains several documents of interest: tapes from panel discussions that occurred at the first four meetings between the American Hospital Association, American Medical Association, the Joint Commission of Healthcare Accreditation, and classification developers; correspondence between the classification developers and nursing’s main professional organization, the ANA; and other related documentation.

The NMDS (archives located at the University of Wisconsin, Milwaukee and Boston University) was an alternative patient record constructed by nurses. The collection contains detailed information about the early development of the data set, including the first national workshop. In addition, personal papers from the creators of the data set, Drs. Norma Lang and Harriet Werley, are available at the Wisconsin archive location. Their collections contain documents on the NMDS, and Dr. Lang’s papers include records from her service on the ANA committees on nursing data sets and on the development of the nursing informatics specialty.

The ANA is a professional organization representing the nearly 2.9 million nurses in the United States. The ANA papers (archives located at Boston College and Silver Springs, Maryland) contained limited sources related to this study. However, some
documents were useful, so the archive is mentioned here. There were also two sets of personal papers related to the ANA included in this study. The extensive professional papers of Irma Lou Hirsch, former ANA staff member, addressed the development of the Social Policy Statement, the Taxonomy Steering Committee, and other related topics of interest. Mrs. Hirsch was an ANA staff member for over twenty years and served as staff liaison to the ANA practice division. Additionally, the personal papers of Lorraine Freitas, former ANA delegate from the state of California, spanned over thirty years of the ANA House of Delegates.

Lastly, part of the primary sources selected for this study included an examination of the charting practices of one institution, the Veterans Affairs San Diego Healthcare System (VASDHS). The material available included paper care plans, clinician job descriptions, and clinical records (both in paper and electronic form) available for existing and deceased patients treated at the site from 1972 to 1990. Information gleaned from this organization was used in chapters 1, 2, and 4 to illustrate a specific trend in charting (care planning), the use of NPs in a healthcare facility, or an example of technology adoption. All necessary Institutional Review Board approvals were completed.

Challenges

Despite variety and depth of the primary sources discussed above, I faced several challenges during analysis and construction of the historical narratives. Conventional interpretations of the development of CIS tend to focus on individual nurses and use heroic or celebratory language to describe these individuals. Moreover, these types of interpretations often depict continual successes with regard to CIS development, and
consistently position these “pioneers” as elevating existing practice. This enables a particular interpretation of bedside nursing that has proved to be neither illustrative nor helpful in analyzing nursing’s participation in the development of CIS. The core challenge to examining the role of these clinicians within the primary sources was the issue of abstraction. Because few clinicians participated in the creation of the various information practices reviewed in this study, their influence had to be viewed either by way of care plans designed by nurses from healthcare facilities across the country, by practice demands, or by the perspectives that were absent in the collections. This practice-up perspective shifted the view away from a “pioneering” narrative toward one of elites struggling to understand and, through information practices, come to grips with extensive changes in nursing practice.
Introduction

Changing Patients, Changing Practice

With the introduction of Medicare in 1965, the number of patients seeking health-related services rose.\textsuperscript{16} This population brought to the hospitals increasingly difficult health problems that were often costly to treat and necessitated complex care.\textsuperscript{17} For that reason, healthcare costs were rising rapidly and strategies to reduce costs, for example, decreasing a patient's length of stay (LOS) in the hospital, became more commonplace. Compounding these trends were changes in the very fabric of care delivery, including new treatments, medications, and technologies.\textsuperscript{18}

Complicated new interventions were being introduced and incorporated into patient care. These new interventions often required of the nurse very specific skills. For example, dialysis machines, used to filter cellular waste from the body when a person's own kidneys have failed, require the nurse to manage running the machine, monitor the patient, and execute an extensive set of information practices, including collection of laboratory results and patient fluid and vital signs.\textsuperscript{19} In addition, interventions such as cardiopulmonary resuscitation, cardioversion, and external pacemakers were being used

\textsuperscript{16} Stevens, \textit{In Sickness and in Wealth: American Hospitals in the 20\textsuperscript{th} Century} (Baltimore, MD: The Johns Hopkins University Press, 1999).
\textsuperscript{19} Ibid.
with growing frequency to treat patients with heart conditions.\textsuperscript{20} These tools were often used in combination with heart-lung machines and increasingly elaborate airway management techniques.\textsuperscript{21} Challenging new surgeries such as chest surgery where artificial heart valves were placed into patients, demanded altogether different nursing care if these patients were to survive these types of interventions.\textsuperscript{22} Additionally, associated treatments such as oxygen therapy, airway suction and surgical wound management shifted the ways nurses cared for patients.

In combination with the above treatments, drugs such as antibiotics and cardiac medications began to significantly alter the types of patients who survived in hospitals.\textsuperscript{23} These patients required increasingly complex medication management that included changes in the mode of delivery (e.g., increasing the number of intravenous injections) and in equipment (e.g., disposable IV tubing).\textsuperscript{24} Moreover, the emergence of chemotherapy, a blunt tool in cancer treatment, necessitated such interventions as reverse isolation. Diseases that had long been life-ending conditions, for example, juvenile onset diabetes, were now treatable but consequently generate a totally different set of chronic

\textsuperscript{21} Keeling, (2004).
\textsuperscript{22} Fairman and Lynaugh, \textit{Critical Care Nursing}.
\textsuperscript{23} Ibid.
conditions. Insulin, while certainly welcomed for its life saving properties, altered the course of the disease, essentially creating different problems to manage.

In order to manage these patients and technologies, new care areas began to form during the time period. In response to these changing patient situations, hospitals added intensive, coronary, and cancer units, as well as surgical recovery rooms. These units were structured to concentrate specialized knowledge and procedures focused on specific types of patient populations. Nurses who worked in these areas became “practice-born specialists” and were increasingly capable of managing shock, airway obstruction, complex surgical site care, and other emerging patient crises. These units and specially trained nurses were able to meet the demands of managing increasingly sick patients and the associated knowledge explosion.

Accompanying these new treatments and care spaces were physical comfort tools, for example, circular electric beds and specialty pressure mattresses. Mattresses, while seemingly unsophisticated tools, offer an excellent example of how even basic nursing care was in flux. In addition, routines as superficially simple as transferring patients from bed to chair were now highly involved processes involving different equipment and increased risks for patients and nurses alike. This, coupled with pushes for early

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27 Keeling, (2004); Fairman and Lynaugh, *Critical Care Nursing*.
28 Cooper, *Contemporary Nursing Practice*. 
ambulation, created altogether different nurse-patient situations. Since the patients were sicker, their transfers (e.g., from bed to chair) and ambulation were more dependent on the nursing staff. This meant more of the patient's weight was moved by the nurse, so more and more nurses began to injure themselves during these processes. While these activities and tools may seem simple, they added layers of intricacy to an increasingly complex care environment.

Additionally, nurses applied old tools such as blood pressure cuffs in new ways, generating additional amounts of information to be managed and interpreted. Providers were also using blood tests, X-rays, and electrocardiograms (EKG) with increasing frequency. The volumes of data produced by the application of these technologies necessitated an altogether different skill set for nurses, specifically the ability to interpret and accurately assess meaning associated with the information. This expectation that nurses provide properly contextualized information was fueled in part by physicians, many of whom relied on nurses to gather volumes of data, filter it into useable chunks of information, and communicate it to them on a timely basis. The union of increased information and shifting expectations produced a much more pronounced

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30 Fairman and Lynaugh, Critical Care Nursing.
interdependency between the nurse and physician than had existed previously. It also became apparent that many nurses lacked the required skills necessary for working in this new hospital environment.

Patients also had shifting expectations when it came to healthcare, including the nursing care they received. Expectation of cure, as well as access to needed services and the latest technologies, were elements of care that patients increasingly anticipated as routine. Patients' expectations about their own roles shifted as they had more access to care, new drugs, surgeries, and other treatments. As patients became more involved with their own care, they began to search out information sources and assistance, especially from the nurses involved with their daily care during hospitalizations.

Although patients continued to hold on to gendered notions of caring associated with nurses, ideas about nursing care and the quality of that care were changing. Patients expected their nurses to be female, dressed in white uniforms, kindly, pleasant, concerned with patients' problems, sympathetic and comforting, but they also began to expect skilled technical care. A nurse needed to be able to identify a patient's emerging

37 Ruth V. Matheney, Brenda Nolan, Alice Ehrhart, Gerald Griffin, and Joanne King Griffin. Fundamentals of Patient-Centered Nursing (St. Louis: C.V. Mosby Company, 1964). This last citation delves into the current expectations citing the need for nurses to be female, kindly, and interested in patient problems. There was also an increased focus on identifying quality issues associated with nursing care. See “Action for Critical
problems and to act quickly and deliberately to reduce, if not eliminate, potential or actual threats to the patient's well-being. Furthermore, care needed to encompass personalized interventions that took into consideration patients' cultural and social needs.

Additionally, patients started pushing the boundaries of control over health-related information. During the 1960s, there were major changes in civil law. A combination of the Consumer Bill of Rights and newly legislated Freedom of Information Act in 1966 (and subsequent Privacy Act amendments in 1977 under the umbrella of the

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original FOIA) produced an interesting mix of patient expectations in relation to healthcare, hospitals, and clinicians. Tension over ownership of personal health information and privacy of information, coupled with the newly coined ideal of patient as consumer (which emulated the meshing of civil, consumer, and patient rights movements), led to the demand for an altogether different set of information practices surrounding health and the provision of healthcare.

John F. Kennedy delivered a speech to Congress on March 15, 1962, in which he outlined four basic consumer rights: the right to be informed, the right to safety, the right to choose, and the right to be heard. See www.jfklibrary.org. This speech came to be known as the “Consumers Bill of Rights.” Following this and a sequence of public acts aimed at strengthening consumer rights, President Johnson signed into law the Freedom of Information Act (5 U.S.C. 552) in 1966. This act was aimed at ensuring the public had access to government information. The original FOIA was followed by the 1974 Privacy Act Amendment intended to address the relationship between individuals and their government in regard to personal information. President Carter felt strongly that the 1974 act did not go far enough and commissioned a report in 1977 in order to further investigate this issue. See Privacy Protection Study Commission, *Personal Privacy in an Information Society, Final Report on Privacy Protection Study Commission* (Washington: U.S. Government Printing Office, 1977). This report addressed numerous issues associated with health information and led to increased tightening of information practices surrounding the area of patient privacy. The FOIA had several additional amendments during this and future time periods. Also occurring during this time was a focus on patient rights. Congress, the American Hospital Association, and others issued proclamations about their respective organization or profession’s relationship to patients. See Helen Turner, “The Patient as a Person in the Treatment Relationship,” *Journal of Health and Human Behavior* 1, no. 4 (1960): 278-284; Leo G. Reeder, “The Patient-Client as a Consumer: Some Observations on the Changing Professional-Client Relationship,” *Nursing Digest* (1973): 56-61; Institute of Medicine, *Searching For A Balance In Medical Data Disclosure: Report of a Study* (Washington, D.C.: author, 1973): 62-97; Nancy Quinn and Anne Somers, “The Patient’s Bill of Rights,” *Nursing Outlook* 22, no. 4 (1974): 240-241; George Annas, *The Rights of Hospital Patients* (New York: ACLU, 1975).

One of the main drivers of this milieu was a growing patient distrust of professional dominance by physicians.\textsuperscript{42} An example of this occurred in 1977 when the Ralph Nader-affiliated consumer organization Public Citizen Health Research Group

the consumer rights movement in healthcare. See Tomes, “Patients of Health-Care Consumers? Why the History of Contested Terms Matters.” Tomes offers a rather pessimistic view of the consumer rights movement in healthcare. She asserts that the movement failed to meet the expectations of its participants; I don’t agree and believe Tomes’ conclusions are premature. I base my disagreement, in part, on Tomes’ initial positioning of medicine and patients, where success for patients is measured by the degree of autonomy and influence patients exert in the context of the physician-patient encounter as well as in market decisions. Moreover, her view does not take into account that decisions about one’s health are dramatically different from decisions about product consumption. This also ignores the influences patients had on physicians and nurses during this time. Nor does it take into account the practical means by which institutions can implement ideas intended to improve practice. Take, for example, the “truth in labeling” component of the Consumers Bill of Rights and the FOIA, as it relates to health information. In an article describing the new information practices surrounding Intrauterine device (IUD), the editor explains the procedure for informing the patient. The physician must give the product insert to the patient, allow the patient to read the information, and answer questions about the product before insertion. See “Food and Drug Administration: Text of Required Patient Information for IUD’s,” \textit{Western Journal of Medicine} 127, (1977): 81-83. It is also important to note that such practices were not isolated to the United States. The influence of consumers was being felt in the United Kingdom as well. See Lancet, Letters to the Editor, January through June of 1966.\textsuperscript{42} The revisiting of patient rights, coupled with the growing dissatisfaction of paternalism, created significant conflicts between medicine and its publics. Issues surrounding patient decision-making abilities, truth, consent, and right to refuse treatment were all being discussed during this time period. In the areas of women’s health, mental health, research, and the treatment of the dying, medicine was coming under fire for exercising control and authority in areas where the public were beginning to believe medicine had no right to do so. All of this combined to create an environment of significant public distrust and disenchantment with medicine. See Alexandra Dundas Todd, \textit{Intimate Adversaries: Cultural Conflict Between Doctors and Women Patients} (Philadelphia, University of Pennsylvania Press, 1989); Susan Reverby, \textit{Tuskegee’s Truths} (Chapel Hill: University of North Carolina Press, 2000); Sissela Bok, \textit{Lying: Moral Choice in Public and Private Life} (New York: Pantheon Press, 1978); James Childress, \textit{Who Should Decide? Paternalism in Health Care} (New York: Oxford University Press, 1982); Jay Katz, \textit{The Silent World of Doctor and Patient} (New York: Free Press, 1984); President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, \textit{Making Health Care Decisions} (Washington, D.C.: U.S. Government Printing Office, 1982); Paul Ramsey, \textit{Patient as Person} (New
(HRG) requested data from the Professional Standards Review Organization (PSRO) regarding (1) hospital admission and LOS data connected to specific physicians and hospitals for patients receiving treatment for acute myocardial infarction and three surgical procedures and (2) statistical profiles of the five identified physicians and hospitals with the largest number of Medicare and Medicaid admissions for those same categories. The agency denied the request. In response, the HRG took the issue to court and sued the agency under the FOIA. The agency argued that, under the act, physician privacy trumped the public right to information. The consumer group argued it had the right to evaluate the care provided if it was paying for it. While court battles ensued, Congress responded by passing a moratorium on any judicial finding requiring disclosure and directed the Institute of Medicine (IOM) to examine the issue and generate a report.

In 1978, the IOM released its report on the issue of information disclosure of PSRO reviews. In the report, the IOM discussed its belief that an informed citizenry was

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Haven: Yale University Press, 1970). Also see Paul Starr’s treatment of this subject. Starr provides a summation of the various civil rights movements influencing this shift in patient trust. While he focuses mainly on the women’s movement and women’s healthcare, the summative findings apply to patients in general. See Paul Starr, The Social Transformation of American Medicine, (New York: Basic Books, 1982), 388-393.

43 The Public Citizen Health Research Group was affiliated with The National Consumer Health Committee formed at the first National Consumer Health Conference held in Berkley, CA in October of 1969. A second conference was held in San Antonio, Texas in February 1972. What emerged out of these conferences was a multifaceted strategy aimed at testing consumer rights; this included areas such as the automotive industry as well.

related to the provision of health information.\textsuperscript{45} Since Medicare and Medicaid were publicly funded programs, the IOM deemed it reasonable and appropriate to disclose information about the quality and use of services, as these disclosures were necessary if the public was to evaluate care delivery and waste.\textsuperscript{46} Further, the report acknowledged the patient as a decision maker.\textsuperscript{47} This acknowledgement recognized the growing reluctance among patients to simply do what the physician recommended simply because he or she claimed a greater knowledge, expertise, or status.\textsuperscript{48} The implications for the PSRO of this lawsuit and subsequent FOIA amendments would unfold over the next few years. Although these were significant changes, the recognition of patient as decision maker is most important to this discussion.\textsuperscript{49}

The patient as decision maker is by far the most complex, value-laden issue addressed in this chapter. The idea raises questions about rights of clinicians and patients, professional autonomy, competence, control, and ultimately, power. Throughout the healthcare literature of the time, discussions about giving patients information were most

\textsuperscript{45} The provision of information about the services rendered under a government-funded initiative was one way for citizens to evaluate such a program.

\textsuperscript{46} Physicians attempted to reframe the information disclosure debate in several ways. One of the more interesting was to cast the information first within the physician-patient relationship and second as physician-patient confidentiality. See Lawrence Altman, "Physician-Patient Confidentiality Slips Away," \textit{New York Times} (September 27, 1983): Section C1.

\textsuperscript{47} This discussion of patient as decision maker started earlier, in the 1960s, with the returning recognition that the patient is a person. See Helen Turner, "The Patient as a Person in the Treatment Relationship," \textit{Journal of Health and Human Behavior} 1, no. 4 (1960): 278-284.


\textsuperscript{49} Limiting access to peer-reviewed data did not stop at the PSROs. As part of the Omnibus Reconciliation Act of 1980, P.L. 96-499, Congress limited public access to peer-review information generated by the VA.
interesting and telling. For example, an American Cancer Society (ACS) nurse, staffing a newly opened information call-in line for patients, answered the hotline number and was asked by a caller “what is a mesothelioma?” According to the article “What to Tell a Cancer Patient?”, the nurse questioned whether she had the right to give the patient the information his physician had not, whether she was responsible for giving the information to the patient, and whether the patient could handle the information. This situation highlighted complex new issues occurring in medical and nursing practice related to communication with patients and between providers. The nurse was now assuming some of the authority and responsibility once the purview of the physician, and more important, the patient was seeking “outside” information to augment the information she or he received within the context of the doctor-patient relationship. Additionally, the ACS was not the only group giving out information once thought to be “owned” by medicine; Harvard opened a patient information center in 1979, as did numerous other institutions across the country.

The ceding of control over health information by physicians did not stop at general disease information, but carried over into practices associated with the patient


record as well. The issue of access to information during hospitalization raised questions about what to tell patients. What could patients make decisions about? And who had the authority to give patients information? The larger issue was that the patient was no longer seeking health-related information solely from physicians, opening up the field for others to provide such services.

All these changes challenged nurses’ current practice experiences, many of which were largely based on knowledge of procedures and rules. This task-centered approach to practice relied heavily on repetition of activities related to patient care and was

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54 “Nursing Practice Briefs: Getting Patients Involved,” *Nursing 89* (June 1989): 68. This is perhaps the most obvious example of how the idea of giving patients information translated into practice. This article presents the idea of a patient activity board. On the board, information about diet, activity level, intake/output status, weight, lab, bath, and X-ray times, and nurses’ names were deemed as important patient information. The rationale given was that this activity board would benefit the patient by providing staff with a quick reference that can act as a reminder, potentially decreasing errors. The board could also function as a review for walking rounds, a communication tool to other staff, and lastly, education for the patient. The irony of this patient involvement tool is that it contained virtually all nursing actives and little information about the actual care being delivered or points where the patient could interact differently with the staff. Anne Porter, Patricia Moschel, Barbara Liederman, and Marge Pope, “Patient Needs on Admission,” *American Journal of Nursing 77*, no. 1 (1977): 112-113; Norma McHugh, Norma Christman, and Jean Johnson, “Preparatory Information: What Helps and Why,” *American Journal of Nursing 82*, no. 5 (1982): 780-782. These articles address what the patient “needs to know,” as determined by the nurse, during different parts of his or her hospital stay. The information was limited to the location of the call light, who their providers were, physical surroundings, expectations related to activities, and preparatory information related to procedures.
increasingly inadequate in meeting patient needs. Many nurses were unable to assess
patients’ response to treatments and illness, integrate varying points of information, and
ultimately make effective decisions about patient care, yet these skills were vital if nurses
were to meet the current challenges of patient care. This lack of skills reflected the
educational preparation of practicing nurses, which was largely obtained in hospital
training schools.

Strategy and Necessity: Changing the Way Nurses Thought about Patient Care

The education and skill level of nurses, coupled with the other trends and changes
mentioned above, created a marked increase in care delivery challenges. These problems
were more pronounced than in earlier decades due to the various new trends in patient
care. These practice changes were not well understood and generated competing problem
definitions and solutions, including augmenting existing information practices,
specialization, establishment of standards of care, and changes in educational preparation.

One of the more readily available solutions was to change the information
practices associated with patient care. During this time period, countless strategies
addressing everything from basic charting schemes to complex information recording
systems were introduced with the intent of shifting the level of nursing care provided to
patients. In a very real sense, information was treated as a proxy for knowledge, the

56 Faye G. Abdellah, Irene L. Beland, Almeda Martin, and Ruth V. Matheney, New
Directions in Patient-Centered Nursing (New York: Macmillan Company, 1974); Jessie
11 (1962): 70-71; Otto Pollak, Charles Westoff, and Marvin Bressler, “Pennsylvania Pilot
57 Abdellah, et. al, New Directions; Scott, (1962); Pollack, et. al, (1953).
58 Faye G. Abdellah, “Methods of Identifying Covert Aspects of Nursing Problems,”
Nursing Research 6, no. 1, (1957): 4-23.
rationale being that if the nurses collected specific pieces of information, they would eventually be capable of identifying which pieces of information indicated a need for targeted intervention. This, of course, was not the case. Collection of information did not translate into increased knowledge of patient problems, at least not in its entirety and not to the extent champions of this strategy intended. This was primarily because collection did not automatically indicate integration into a nurse’s thinking.  

Changes in health information trends began with early demands to gather, store, organize, codify, and mobilize data for practical as well as political purposes. Although sharp increases in health information collection began early in the twentieth century with the introduction and use of new diagnostic technologies such as the X-ray machine and various lab tests, the changes in the late twentieth century, described in the pages ahead, created a particular demand for information and the tools to manage this information.  


Increased collection and use of health-related information begins in the early part of the nineteenth century in areas such as public health for surveillance of infectious diseases such as tuberculosis. For an example of the political use of health information, see E. W. Kopf, “Florence Nightingale as Statistician,” *Journal of the American Statistical Association* 15 (1916): 388-404. While the article is a general overview of the statistical practices of Nightingale, we can see how statistics were used to call attention to the horrible conditions of field hospitals and the subsequent deaths of British soldiers.  

In the hospital during this same time period, we see an increase in information surrounding the uptake of technologies such as the X-ray, and lab tests such as the urine analysis. While I am not suggesting that the collection of health information has its origins in the early part of the twentieth century, there was an increase. See Joel Howell, *Technology in the Hospital* (Baltimore: Johns Hopkins University Press, 1995).
The need to manage information during this time dramatically increased due to expanded access to healthcare, the growing role of government and other third-party payers, elevated standards of care, and public expectations for increased access and openness regarding health information.

Trends in information and its uses in healthcare closely follow reimbursement patterns. Beginning with passage of the 1965 Social Security Act Amendment and its enactment in 1966, the U.S. government provided members of the population who were sixty-five years or older with healthcare coverage. Medicare and the federally subsidized state-run program, Medicaid, addressed the growing number of poor without access to care by expanding the number of individuals insured. This economic focus on extending care to those in need, while an altruistic goal at the outset, also extended economic opportunities to healthcare providers. The more diverse the services offered by hospitals and providers, the more opportunities they had to bill.

This dynamic continued even with the 1972 amendments to the Social Security Act that, while tightening the regulations regarding reimbursement, expanded the program to cover additional patient populations, for example those individuals suffering from renal failure and various disabilities. With this continued influx of cash (in the form of newly covered patient populations) into the healthcare system, shifts in patient expectations for both hospitals and clinicians began to occur. There was increased pressure from the public for hospitals to provide evidence of quality and cost

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62 For an in-depth treatment of the economic issues surrounding healthcare during the twentieth century, see Stevens, *In Sickness and in Wealth.*

63 Ibid.
effectiveness in the care being provided. One means of doing so was record keeping. Record keeping in the late 1960s and early 1970s was a piecemeal operation, consisting primarily of narrative physician notes, test results, and basic demographic information. Nurses' notes were practically nonexistent, consisting of short vague phrases such as "usual" or "typical day." This is, of course, a generalization, for in some developing specialty areas, for example, intensive care units, nurses were charting a great deal more, including vital signs, treatment, treatment evaluations, and longer, more descriptive narratives about the care delivered. Still, that type of charting was not the norm during the early part of this time period.

In the years that followed the passing of the 1965 Social Security Act Amendment, program costs rose dramatically. Even as the costs associated with the Medicare program continued to rise, Congress remained focused on evaluating the program in terms of quality. However, Congress lacked the means to evaluate care provided. As a result, the 1972 Amendment included provisions for regulations that

64 Following the 1972 expansion of services, the National Health Planning and Resource Development Act of 1974 was passed. This act was primarily aimed at controlling the spread of medical technology and folded into the act were measures of payment control. This act introduced the certificate of need; without this certification, Medicare payments could be denied. These certificates of need fell under the purview of the Professional Standards Review Organizations that were established in the 1972 legislation.

65 Marilyn Hansen, “Doing It Better: Make Your Charting the ‘Topic-of-the-Day,’” Nursing 76 (May 1976): 74. This article proposed that nurses focus their charting each day on a different topic: personal hygiene on Tuesday, diet on Wednesday, and so forth. Earlier articles that began peppering the professional journals cited the need for, and responsibility of, nurses to chart. See Nathan Hershey, “The Law and the Nurse: Medical Records and the Nurse, Part 1,” American Journal of Nursing 63, no. 2 (1963): 110-113; Nathan Hershey, “The Law and the Nurse: Medical Records and the Nurse, Part 2,” American Journal of Nursing 63, no. 3 (1963). This column lasted for a little over a year and addressed topics related to shifting changes in nursing’s responsibilities.
addressed means for assessing quality of care.66 Now, “quality of care” was a term
used broadly and with varying meanings depending on where you were in the healthcare
arena. For Congress, it meant information about billing and standards of care; for the
Joint Commission for Accreditation of Hospitals (JCAH), it meant organizational
sustainability. If hospitals wanted to continue receiving Medicare funds, they had to
"voluntarily" submit to JCAH evaluations, which focused in part on record-keeping
practices.67 Just prior to the passing of this 1972 Amendment, JCAH had formed several
committees to examine information practices at hospitals. The findings of these
committees, and the regulations that followed, shifted the focus of clinician charting.

For medicine and nursing, these changes required a shift from relatively
unstructured to structured narrative notes.68 An example of this type of charting format
was the problem-oriented medical record (POMR), introduced by Lawrence Weed in
1969.69 Weed’s method of charting emphasized identifying a problem list for patients, a

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66 Stevens, In Sickness and in Wealth.
67 Robert M. Cunningham, Jr., Governing Hospitals: Trustees and the New
68 For nurses, this meant an increase in the amount and a change in the format of their
charting practices. See Rita Petruska, “A One-Page Record for Prematures,” American
Journal of Nursing 63, no. 3 (1963): 66-67; Virginia H. Walker, Dorothy A.
McReynolds, and Elsie Patrick, “A Care Plan For Ailing Nurses’ Notes,” American
Plans and Their History,” Nursing Outlook 21, no. 6 (1973): 378-379. Unlike nursing’s
charting, which was sparse, physicians were charting what was often characterized as
verbose notes. See Bruce Blum, “Medical Informatics in the U.S. 1950-1975,” in A
History of Medical Informatics Bruce Blum and Karen Duncan eds., (New York: ACM
Press, Addison-Wesley); Bonnie Kaplan, “The Computer Prescription: Medical
Computing, Public Policy, and Views of History,” Science, Technology and Human
69 Lawrence Weed, “Medical Records that Guide and Teach,” New England Journal of
See Lawrence Weed, Medical Records, Medical Education and Patient Care: The
list that was used consistently across the various types of clinicians who came in contact with the patient during the course of a hospital stay. As each clinician worked with the patient, he or she would document, in the narrative portion of the chart, a given problem using the SOAPE format: subjective, objective, assessment, plan, and evaluation. With Weed's method, there were no separate sections for medicine, nursing, or other types of clinicians.

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Problem-Oriented Record as a Basic Tool (Cleveland, OH: Case Western Reserve University Press, 1969).

Weed was not the only one proposing and implementing a combined record. See Elizabeth Morgan, "New Chart Forms, Solve Old Problems," American Journal of Nursing 65, no. 3 (1965): 93-96. In the article, Morgan discusses changes in the record-keeping practices of the University of Illinois Medical Center. These changes in existing charting addressed two issues: the lack of readily accessible, clear vital sign measures (pulse, temperature, respirations, intake/output, diet, and sleeping pattern) and the sporadic appearance of nurses' notes. Resistance to this new form of charting existed among the nursing staff and medical staff for different reasons. Nurses, having previously limited charting to recording of sporadic vital signs, were now being asked to write in the chart in narrative form. This was a new task and one that necessitated thinking differently about their work and the patient. For medicine, the change meant sharing "their" record with another clinician; any objection to this, according to the author, was quickly overcome once the physicians saw the utility of this new information source.

There were champions of this form of charting within nursing. See Mary Woody and Mary Mallison, "The Problem-Oriented System for Patient-Centered Care," American Journal of Nursing 73, no. 7 (1973): 1168-1175; Judith Bloom, Joan Dressler, Michele Kenny, Doris Molbo, and Geraldine Pardee, "Problem-Oriented Charting," American Journal of Nursing 71, no. 11 (1971): 2144-2148; Pamela Schell and Alla Campbell, "POMR—Not Just Another Way to Chart," Nursing Outlook 20, no. 8 (1972): 510-514. There were also nurses who objected to the adoption of the POMR. See Jan Malloy, "Taking Exception to Problem-Oriented Nursing Care," American Journal of Nursing 76, no. 4 (1976): 582-583. The author objects to POMR because of the approach to patients based on their problems. She believes that this focus is damaging to the nurse-patient relationship since it frames the patient in terms of deficit and subsumes nursing actions under medicines. There were also nurses who adopted a more middle-of-the-road stance on the POMR. See Joanne McCloskey, "The Problem-Oriented Record vs. the Nursing Care Plan: A Proposal," Nursing Outlook 23, no. 8 (1975): 492-495. The article discusses the uses of the POMR, and specifically the use of SOAP (without the E for evaluation), as needed improvements in existing nursing care plans.
However JCAH, through the workings of its committee on nursing practice, had other ideas about what and where nurses should be charting. If hospitals wanted to be certified to receive Medicare funding, the JCAH required that they develop care plans that focused solely on nursing activities and encompassed elements of assessment, goal setting, nursing actions, and evaluation. Prior to the 1972 amendment, the JCAH accreditation standards for nursing were a short three paragraphs, with one paragraph providing direction on record-keeping requirements. Perhaps because these standards were somewhat vague, hospitals and clinicians responded by collecting many different types of data in many different forms. Nurses' frustrations about the creation and maintenance of these forms grew; one article found in the *American Journal of Nursing* that typified the frustration of staff nurses is titled “Care or Snare Plan.”

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72 JCAH worked in a limited fashion with the American Nurses' Association (ANA) to develop these new standards, which emphasized the content and function of NCP rather than what had been previously articulated. See John Porterfield, “Joint Commission: Tougher to Please in 1971,” *American Journal of Nursing* 71, no. 1 (1971): 70-74.

73 JCAH's 1972 *Accreditation Manual for Hospitals*, Nursing Services Standard IV stated the following: “There shall be evidence established that the nursing service provides safe, efficient, and therapeutically effective nursing care through the planning of each patient’s care and the effective implementation of the plans,” 3.

74 Prior to the shift from clinical tool to regulatory compliance mechanism, the care plan, sometimes called admission interview or problem list, contained a variety of material needed to coordinate care, but also improve the knowledge base of the nurse. Admission Interview and Nursing Assessment, 26 November 1969, Irma Lou Hirsch Papers, Private Collection, Author. However, after the regulation was implemented, the care plans changed to standardized data collection forms. This was a fairly dangerous change, as the majority of nurses had not yet become accustomed to the changes in practice reflected in the pre-regulation form. It was dangerous because many of the nurses were just learning the new technologies, and so forth, and were not yet able to differentiate when a deviation from standards were in fact the better route for the patient. Alcoholism, Discharge Criteria, El Camino Hospital, 1974, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.

75 Helen Palisin, “Nursing Care Plans Are a Snare and a Delusion,” *American Journal of Nursing* 71, no.1 (1977): 63-66. There were numerous letters written in response to the
reporting, in this and other forums, their distaste for the new charting tool partly because their charting duties were growing exponentially, and partly because their practice was changing. Nurses were no longer able to simply do for the patient; they had to demonstrate what they were doing through documentation.

Hospitals, while certainly focused on these clinical regulations, began to automate their various information systems as a means to meet the rising need for information. The push for automation of business processes resulted in hospitals often relying on systems originally conceived for use in other types of organizations such as manufacturing. Management Information Systems (MIS) were originally designed primarily to eliminate middle management functions and improve decision-making capacities. The basic assumptions were that the information provided by these systems would improve

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decision-making capabilities, and that errors occurred because of a lack of information. These information trends in business coincided nicely with the information needs of hospitals at the time.

Hospitals implemented automation of various business processes primarily in areas where administrators believed billing operations could be improved. Hospitals introduced computers first in the billing operations, with laboratory, pharmacy, dietary, and imaging services to follow. The initial adoption of computers in these areas made sense, for the computerized systems matched other basic cost accounting functions already in use on paper. Consequently, hospitals often located the computer in a central

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79 Charles Goshen, “Your Automated Future,” American Journal of Nursing 72, no. 1 (1972): 62-67. Automation of nurse staffing was also an interesting application during that time. This was a frequent “first system” of nursing information implemented to track employee hours. Veterans Administration Hospitals were particularly keen on these type of systems. Classification of Patients According to Nursing Care Needs, Veterans Administration Hospital, Tuscaloosa, Alabama, 8 April 1977, Irma Lou Hirsch Papers, Private Collection, Author; Martin Engle, Deputy Medical Director, Veterans Administration to Area Medical Directors, Area Medical Offices and Directors of VA Hospitals, 19 November 1963, Irma Lou Hirsch Papers, Private Collection, Author; Reasons for Need of Patient Categorization, 1963, Irma Lou Hirsch Papers, Private Collection, Author. Also see Barbara J. Stevens, “Analysis of Trends in Nursing Care Management,” Journal of Nursing Administration (November-December 1972)12-17; June B. Somers, “Purpose and Performance: A System Analysis of Nurse Staffing,” Journal of Nursing Administration (February 1977): 4-9; Merrill Lehman and Quinton Friesen, “Centralized Control System Cuts Costs, Boosts Morale,” Hospitals 51 (May 1977): 75-80; Claire O’Malley, “Application of Systems Engineering in Nursing,” American Journal of Nursing 69, no. 10 (October 1969): 2155-2160.
site in the hospital or in some cases, off-site, with multiple hospitals using one mainframe computer.\textsuperscript{80}

Diversity of services, and other means of creating revenue opportunities dominated during this time, but as the costs of these new programs continued to rise and the country entered into a recession, changes in revenue streams began occurring. Healthcare responded pragmatically, curtailing growth by moving away from the never-ending expanse of services. This move shifted the economic focus from providers to payers and ushered in different information needs.

If charting for nurses in the 1970s was typified by “usual day” and “care plan or snare plans,” charting in the 1980s was all about “charting for dollars.”\textsuperscript{81} The excesses of the 1970s funding streams were replaced by new regulations that introduced diagnosis-related groups (DRGs). With the passing of the 1982 Tax Equity and Fiscal

\textsuperscript{80} An example of this off-unit computer is seen in this excerpt in \textit{American Journal of Nursing} where a nurse is standing off unit in a room surrounded by a series of large computers. The caption describes the IBM RAMAC 305 computer and how it will “mechanize” existing processes such as food ordering. See “Lightening the Nurse’s Load,” \textit{American Journal of Nursing} 62, no. 5, (1962): 95. Also see J. Eisler, P. Goering, and M. Tierney, “Strangers in Computerland,” \textit{American Journal of Nursing} 72, no. 6 (1972): 1120-23. This article is an example of the computer being housed offsite. Additional examples: Margo Cook and Wanda McDowell, “Changing to an Automated Information System,” \textit{American Journal of Nursing} 75, no. 1 (1975): 46-51. There were other computer-based patient monitoring systems that began to move to the bedside much earlier, but they served an altogether different purpose. See Rita Chow, “Patient Monitoring is More Than Just a Dream,” \textit{American Journal of Nursing} 61, no. 11 (1961): 60-62; Claire D. O’Malley, “Nursing in a Space-Age Hospital,” \textit{American Journal of Nursing} 62, no. 12 (1962): 54-57; and Margaret Bean, Frances Krahn, Barbara Anderson, and Mabel Yoshida, “Monitoring Patients Through Electronics,” \textit{American Journal of Nursing} 63, no. 4 (1963): 65-69. This locating of the computer mirrored the uptake of computers in business as well. See Richard John, “Rendezvous with Information? Computers and Communications Networks in the United States,” \textit{Business History Review} 75, no. 1 (2001): 1-14.

Responsibility Act and its implementation in 1983, the primary assumption embedded in the government’s cost containment effort was that all patients with the same or related diagnoses required the same care. Essentially, the care provided had to comply with an established set of standards linked to a particular diagnosis or cluster of diagnoses. The government set standards based on what was considered appropriate treatment, LOS, and service intensity for a given diagnosis. Hospitals and physicians opposed these new standards, though for different reasons. For medicine, the notion that a payer would dictate practice was a direct threat to physician autonomy. The capacity to determine what medical care would be rendered to a patient was no longer overtly and publicly the physician’s decision. Instead, these standards blurred the lines between the administrative and medical functions of the hospital. The government, through affiliates such as the PSRO, tracked information about patient diagnosis and subsequent treatment, and made that information available to outside groups.

One can see evidence in the literature of the response to these new oversight standards—mini-rebellions of noncompliance regarding information practices, and a more defensive practice of medicine—as physicians were faced with justifying their choices of diagnostic technology application and subsequent treatment.

From a practical standpoint, DRGs required healthcare providers to focus on capturing information about treatments, medications, and other interventions such as labs

82 Stevens, *In Sickness and in Wealth.*
83 The Professional Standards Review Organization was one specific group involved with evaluating the information collected. Part of its function was to certify clinicians and hospitals for certain types of procedures and other functions as a means to control costs. This, however, also meant that the PSRO and similar groups held significant power over the practice of medicine.
or imaging studies, done on behalf of patients. On the surface, this seemed similar to
the charting for charge capture that occurred in the 1970s; however, the information
needs differed now. Rather than direct billing for services rendered, hospitals had to
demonstrate compliance with DRG billing capture categories. This meant that hospitals
had to change the way they used computers, since it was no longer acceptable to simply
capture costs more quickly through automation. If providers wanted to be paid, they had
to capture costs in a way that integrated information across a patient’s stay and
corresponded to the admitting diagnosis.

Since the crux of hospital billing had to do with capturing various clinicians’
actions on behalf of the patient, the computers that were previously housed off-site or far
removed from the clinical areas of the hospital were moved onto the units and other “cost
centers” throughout the hospital. As hospitals added additional cost capture points,

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84 A note needs to be made here about the types of automation occurring in the hospital
and how it differed from the Management Information Systems (MIS) implemented
during this same time period. The automation occurring in hospitals, as it related to
billing practices, was a retrospective reimbursement. Basically, the hospital was paid for
services already rendered. This process deterred outright adoption of MIS for two
reasons; first, there was no incentive to apply any limiting controls; second, there were no
incentives for efficient use of resources. While this changed slightly with the passing of
the SSA of 1965, there was no real incentive to change these practices in any substantial
way until the introduction of the diagnosis-related group (DRG). After the DRG, the
central tenants of MIS (limiting controls and efficient uses of resources) were needed if
hospitals were to be successful financially. This shift brought on the introduction of
management engineers.

85 An additional factor in determining just how far these types of cost capture systems
grew was organizational status (government, for-profit, not-for-profit). A trend occurring
during this time was cost capture of supplies by patient. In other words if the patient
needed x number of dressing kits, each of those kits would be charged directly to the
patient’s bill. This practice was not uniform and was dependent upon organizational type.
Kaiser Permanente is a not-for-profit HMO, and even with the pressures for cost capture,
maintained separation between room costs, general care costs assessed by level of
service, and patient fees (as did the VA hospitals).
issues arose that pushed the focus away from mere automation of services and toward integration. The business sector addressed similar issues of integration as well. However, unlike the mix of continued automation and integration found in healthcare, business was far more focused on integration alone. This use of information technology for the integration—and centralization—was a contemporaneous trend in business, and the overlap of ideas and personnel fit nicely into healthcare and the information demands at the time.

Medical information practices remained fairly stable during this time. The notions of LOS, service intensity (measured by level of care), and matching treatment received to the diagnosis rendered, though controversial, necessitated a fairly straightforward series of information practices. The existing information practices, for example, POMR and SOAPE, were augmented to integrate DRGs. The changes imposed on the medical profession were focused not so much on what individual clinicians were charting but on matters of standardization. The idea that medicine could be standardized, predictable, and controlled was at odds with the ideals of medical autonomy. Cries of interference with the doctor-patient relationship, while having some basis in the removal of physician judgment from the treatment equation by predetermined treatment plans, were largely rhetorical signifiers aimed at soliciting public support. This set up of standardization by the government programs mirrored the MIS widely introduced in business a decade earlier. The MIS was aimed at removing middle management and improving decision-

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making capabilities in the name of profit. While not identical to its purpose in healthcare, it certainly informed the development of information practices within healthcare. Moreover, using MIS to manage care through the use of information, rather than keeping this management in the hands of physicians, was a contentious notion, and it exemplifies the politics of information and practice in health informatics systems.

The same information practices that worked fairly well for tracking lab tests, medical treatments, and imaging orders by DRG correlated fairly consistently with actual medical practice. Yet for nursing, the equation was not as simple: nursing lacked an independent cost center. The fees associated with nursing's patient care activities were embedded into the room costs that, under the DRG payment system, were folded into

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service intensity and LOS. In an attempt to separate nursing charges from room charges, nurses undertook various strategies ranging from “charting for dollars” to development of acuity rating tools.\(^{90}\)

Charting for dollars required nurses to attempt to account for each and every activity performed for patients through documentation.\(^{91}\) This mirrored the activity occurring throughout the hospital—the more information captured about activities of patient care, the more evidence to support DRG billing practices. It was hoped that, with this large chunk of information, a connection could be made between DRG categories and nursing tasks performed. Unfortunately, several research findings indicated that there was little or no connection between nursing tasks and DRG categories. Instead, nursing tasks were far better matched with the length of a patient’s stay.\(^{92}\)

\(^{90}\) This was not a new information practice. However, unlike previous attempts to assign a value to nursing based on the number of work hours a particular patient or group of patients consumed, acuity tools attempted to more closely estimate nursing demands. These tools did so by assigning values to specific interventions undertaken by the nurse. See Elizabeth Nancy Lewis and Patricia Vince Carini, *Nurse Staffing and Patient Classification* (Maryland: Aspen Systems Corporation, 1984); Janet C. Scherubel and Franklin A. Shaffer, eds., *Patients and Purse Strings II* (New York: National League for Nursing, 1988); Franklin A. Shaffer, ed., *Patient and Purse Strings: Patient Classification and Cost Management* (New York: National League for Nursing, 1986); J. P. Young, P. G. Giovannetti, D. Lewison, and M. Thoms, *Factors Affecting Nurse Staffing in Acute Care Hospitals: A Review and Critique of the Literature* (Hyattsville, MD: U.S. Department of Health, Education and Welfare, 1981).


Attempting to address nursing’s relationship to service intensity was an alternative to the charting for dollars strategy. Service intensity’s effect on medical practice was, to a certain extent, readily accounted for and actively limited. One could reasonably capture the number of physician visits per patient; and, as a patient became increasingly ill, there would be a logical increase in visits. This corresponded nicely with the type of service for which the patient was admitted or unit to which the patient was transferred, during the course of his or her stay.

Although the levels of care within a hospital (e.g., emergency, intensive care, telemetry, or general medical surgical units) lent themselves readily to the DRG payment system, service intensity was a far more challenging issue for nursing. For example, whereas patients requiring mechanical ventilation fell into the service intensity category of intensive care, problems arose when two patients required that same level of service but required altogether different intensities of nursing care. In response to this complexity, some in the nursing community developed a series of emerging tools called patient classifications. The aim of these classifications was to more accurately measure acuity of patients and amount of nursing care received. The challenge of

93 The results presented in this study are a bit misleading. The authors state that their findings support a connection between DRG categories and nursing tasks, when in fact the purpose of the study was to test an acuity tool. The study essentially demonstrated a connection between the patient’s LOS and DRG categories.

93 Basically, acuity ratings attempted to quantify several factors: how sick the patient is at a given moment in time, the amount and complexity of technology being used, and the intensity of nursing care needed. The acuity ratings were used for several different ends: to attempt to explicate the nursing care activities for a patient, but also (a bit later in the decade) to estimate staffing needs. Discussion on this type of system began much earlier and took many forms, see Janet Price, “Patient Care Classification System,” Nursing Outlook 20, no. 7 (1972): 445-448. Price classifies patients into three primary categories:
measuring the amount, complexity, and intensity of nursing care, while generating a significant number of information practices, would ultimately just scratch the surface of the problem of measuring nursing influence on patient outcomes. However, the immediate impact of service intensity was the generation of additional information practices not previously conceived of in the decades before.

If integration and standardization largely characterized the 1980s information trends in both business and healthcare, the early 1990s ushered in an entirely different set of practices meant in part to address “information overload.” Attempting to deal with essential nursing care, progressive nursing care, and comprehensive nursing care. Essential nursing care is the basic care needed by each patient including baths, diet needs, and ambulation requirements. Progressive care is the type of care needed to move the patient to a different level of functioning, such as managing his or her own colostomy bag. Comprehensive care is the type of care that necessitates an altogether different level of management by the nurse. As you can imagine, the more complex the care, the more skilled the nurse needed to be in order to safely provide the care. This led the author to develop additional classifications for the type of nurse needed with each level.


95 This idea was not new to this time period, as discussion of information overload began much earlier. See John C. Green, “The Information Explosion—Real or Imaginary?” *Science* 144, no. 3619 (May 6, 1964): 646-648. This idea was beginning to build momentum in the early 1980s. See Charles O’Reilly, “Individuals and Information
this phenomenon, business shifted focus away from production of information through automation and integration, and toward framing information practices as a means for gaining competitive advantage. Emphasis on the strategic use of information created a burgeoning series of new business services aimed at strategic information planning.\(^{96}\)

One of the most important strategies businesses used was to focus data collection efforts closer to the source of a given business process.\(^{97}\) Decentralization, as it was called in the business arena, meant moving various data collection functions closer to the source of information.\(^{98}\)

For healthcare, this meant moving computers from the unit or cost center to the bedside.\(^{99}\) Other services, for example, imaging and laboratory, also moved closer to the

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point of care and created yet another shift in information practices.\textsuperscript{100} Though the interpretation and application of DRGs in the 1980s based charting practices squarely on the premise that more information equaled evidence of activity (which then equaled more reimbursement), the 1990s were about a “less is more” strategy.\textsuperscript{101} Charting by exception was partly a response to information overload, but it was also a way to address the rising costs associated with information burden.\textsuperscript{102} Charting only what was done for the patient outside of expected norms was supposed to reduce the now expansive information practices surrounding patient care, limit the paper burden faced by nurses and other clinicians, and improve overall efficiency.

In addition, this movement to charting by exception and decentralization of services was brought on by shifts in the healthcare market. In the late 1980s and early 1990s, Health Maintenance Organizations (HMOs) were hitting their stride. These

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\textsuperscript{100} This trend of moving services to the bedside was often referred to as patient-focused care (PFC), see D. O. Weber, “Six Models of Patient-Focused Care,” \textit{Healthcare Forum Journal} 34, no. 4 (July/August 1991): 23-31. It is not to be confused with progressive-patient care that dealt primarily with levels of service. See L. Weeks, \textit{The Complete Gamut of Progressive Patient Care in a Community Hospital} (Battle Creek, Michigan: W.K. Kellogg Foundation, 1967).

\textsuperscript{101} We started to see the beginnings of this trend during the mid 1980s when the NCP and flow sheets mentioned earlier began to merge into one form, limiting the space used by nurses to chart. See Paula Rich, “With This Flow Sheet Less is More,” \textit{Nursing} 85 15, no. 7 (July 1985): 25-30.

\textsuperscript{102} Laura J. Burke and Judy Murphy, \textit{Charting by Exception: A Cost-Effective, Quality Approach} (New York: John Wiley & Sons, 1988); Judy Murphy, “Charting By Exception: A More Efficient Way to Document,” \textit{Nursing} 90 (May 1990): 65-69. It is important to note that charting by exception did not completely eliminate the NCP; instead, there was a concurrent trend of standardizing care plans and augmenting them with flow sheets. See Donna Deane, Mary J McElroy, and Susan Alden, “Meeting Requirements While Maximizing Productivity,” \textit{Nursing Economics} 4, no. 4 (1986): 174-178.
organizations attempted to tighten the belt, so to speak, by negotiating reimbursement fees with insurance, suppliers, and others to control costs. On the clinical side, this meant a further heightening of cost control, and a focus on streamlining charting and other related processes. Charting by exception, as described previously, fit nicely with this new focus.

One of the main ways that nurses were integrating information was through physical examination or assessment. The intent of making physical examination and assessment a part of nursing was to begin to cultivate nurses' ability to differentiate between raw data and meaningful patient information. Assessment, as it was largely called in the nursing literature, was a skill that physicians had commonly used to diagnose particular diseases. Although certain nurses (namely, NPs) who began


105 For an interesting play on the language used by nursing and medicine, see Joan Lynaugh and Barbara Bates, “The Two Languages of Nursing and Medicine,” American Journal of Nursing 73, no. 1 (1973): 66-69.
practicing during this time period used assessment as a diagnostic tool, for the majority of nurses, this was a new area of practice that had largely been physician territory.\textsuperscript{106}

However, with patient care demands changing, nurses who worked in hospitals in general roles began to need the skill of assessment as well.\textsuperscript{107} Initially, the demand for nurses who had this skill was largely contained within the specialty areas mentioned above such as intensive care units, but the need for the skill gradually spread to other areas of practice. This spread met with concern over whether nurses were adequately trained and prepared to use the skill, and controversy erupted over whether nurses should incorporate assessment into their practice.\textsuperscript{108} Popular nursing publications of the time often portrayed assessment as a skill owned by medicine. This point of view was reinforced by the American Medical Association (AMA) and some in nursing who

\textsuperscript{106} The AMA had made an attempt to limit the use of assessment to physicians only but had to retract the resolution because of a significant push back from hospitals and practicing physicians. Both groups argued that nurses had to be allowed to perform a physical exam because if nurses did not, money would be lost. Agenda Item #26, Memo, Subj: Resolutions adopted by AMA HOD Annual Meeting Chicago, IL. June 7-11 1981, Carol Eady to Judith Yates, 14 August 1981, ANA Papers, History of Nursing, Howard Gotlieb Archival Research Center, Boston University.


\textsuperscript{108} For treatment of assessment as controversial, see Patricia Brandt, Peggy Chin, and Mary Ellen Smith, \textit{Current Practice in Pediatric Nursing, Volume 1} (St. Louis: C.V. Mosby Co., 1976); For a more pragmatic approach, see Joan Lynaugh and Barbara Bates, “Physical Diagnosis: A Skill for All Nurses?” \textit{American Journal of Nursing} 74, no. 1 (1974): 58-59.
objected to nurses performing assessment (in part because of the skill’s reductionist foundation).\textsuperscript{109}

Despite these objections, nurses gradually took on assessment as part of their skill set and steadily integrated it into their routines. Yet while nurses used assessment in ways similar to physicians, they also applied the technology in different ways, primarily as a surveillance tool. While physicians most often used assessment in intermittent intervals, typically spaced out across a patient’s stay or during specific procedures, nurses were using the tool with increasing frequency and for slightly different complex ends.\textsuperscript{110}

Nurses applied assessment to patient care in a very broad way that encompassed treatment and prevention of complications but also combined that function with evaluating things such as the information needs of patients and patients’ heterogeneous responses to illness.\textsuperscript{111} Moreover, nurses were under increasing pressure to incorporate a patient’s personal explanation of his or her illness into the care provided.\textsuperscript{112} In essence, nurses used the tool to address the ebbs and flows of patients’ illnesses rather than identify a particular disease (although they certainly did that as well). While the diagnostic label certainly mattered, and served as a marker in patients’ lives, assessment

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\textsuperscript{111} Dorothy Smith, no title, no date, F 72, unpublished manuscript, Dorothy Smith Papers 1954-1977, Barbara Bates Center for the Study of the History of Nursing, University of Pennsylvania.
\textsuperscript{112} Abdellah, (1957); Abdellah and Levine, (1957).
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was a single point in a long, iterative process that comprised the patient’s illness experience.  

Nurses who wrote about this new tool had high expectations for its application to nursing practice, expectations that often sandwiched nurses between highly gendered notions of nurses’ work and the more masculine technical use of assessment as a diagnostic tool commonly associated with physicians. Nurses were increasingly expected to use assessment to accomplish skilled technical care that was also individualized to meet specific social and emotional needs of the patient. This push and pull highlighted the tensions and difficulties experienced by practicing nurses who were primarily trained to focus on tasks.

The uptake of the skill of assessment crossed nearly all areas of nursing practice, but assessment alone was insufficient to meet the complex needs of patients. A steady growth of specialization in nursing during this time period was another strategy used to meet the demands of sicker patients and the accompanying new knowledge necessary to provide their care. The majority of these specialties were “practice born,” emerging from the bedside out of sheer necessity. Eager nurses who were willing to take up new ideas, treatments, and responsibilities provided for growth of specialty areas such as intensive

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care, coronary care, oncology, and dialysis. Nurses began to seek support from a variety of sources, including emerging specialty nursing organizations. Early on, these organizations offered a place where nurses working in these new areas could discuss their changing roles and receive critical training not offered in nursing education programs.

Nursing educational programs were acutely aware of the deficiencies of their curricula in preparing nurses to work in specialty areas, and in preparing general graduates. Educational program standards were under intense revision for numerous reasons, one reason being the shift occurring from hospital-based diploma programs to programs based in community college and university settings. What nurses needed was curriculum content that included both university requirements and clinical preparation, and choices had to be made about what types of courses were vital to the preparation of nurses if they were to meet the changing demands of patient care. In addition, changes in the curriculum were necessary if schools were to meet the needs of new graduates and employers, both of whom were experiencing a new type of practice environment with its own demands.

This was a complicated transition for schools, which were now expected to prepare not only general graduates but also graduates who could work in emerging

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116 Fairman and Lynaugh, *Critical Care Nursing.*
specialty areas. Compounding these challenges was the accompanying explosion of new knowledge required for patient care. The regular introduction of new medications and treatments, and accompanying new technologies made it difficult to predict what content was most suitable for inclusion in the curriculum.

Setting standards for educational preparation took many forms. Two organizations, the National League for Nursing (NLN) and a newly formed organization, American Association of Colleges of Nursing (AACN), introduced basic curriculum standards in an attempt to meet these challenges. Setting standards was a means for schools and the member organizations to which they belonged to get a handle on the rapidly changing expectations for their programs. The NLN and AACN’s deliberation on streamlining nursing’s entry-level preparation to the baccalaureate level made schools’ decisions about curriculum changes even more difficult. Entrenched in these deliberations was the need to identify what nurses’ scope of practice should be, identify the standards of care associated with that scope, and in general, define nursing’s responsibility to the public.

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119 Joan Lynaugh, “Choosing a Direction: Nursing Education in the University Since 1965,” (Bullough Lecture, School of Nursing, UCLA, March 2005); Joan Lynaugh, “What We Know, We See,” (University College Dublin, School of Nursing and Midwifery, March 2005).
120 Lynaugh, “Choosing a Direction.”; Lynaugh, “What We Know We See.”
There was much debate over defining nurses' scope of practice and standards of nursing care.\textsuperscript{123} Nursing's professional organization, the American Nurses' Association (ANA), revisited key policy positions during this time via revision and creation of two documents: the Standards of Clinical Practice and the Social Policy Statement.\textsuperscript{124} While earlier iterations of these policy statements existed, the ANA chose to revise and further develop these statements at this time to address the rapid changes mentioned above. In addition to the policy statements, the ANA established a certification program in 1973 to provide recognition of expertise in a defined functional or clinical area of nursing.\textsuperscript{125}

Conclusion

Whether it was information practices associated with patient care, assessment, specialization, changes in education standards, or practice standards and credentialing, nurses attempted to use information to meet the changes occurring in practice. Defining the problems confronting nurses in numerous ways—as a deficit in skills, a lack of appropriate information management tools, or deficient preparation—prompted those in nursing to develop a variety of strategies to meet these new challenges. In the following chapters, we will examine three different responses to the problems: a classification, a

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\item \textsuperscript{123} See the editorials and viewpoint letters in \textit{Nursing Outlook}, \textit{American Journal of Nursing}, and \textit{RN}, discussed this topic during the 1970s and 1980s.
\item \textsuperscript{125} ANA formed the Interdivisional Council on Certification in 1976. It was a group internal to the ANA that attempted to negotiate credentialing rights with specialty organizations. Summary of Major Certification Policies, American Nurses Association, March 1986, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee. Also see http://www.nursecredentialing.org/inside/index.html
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definition of nursing practice, and a MDS. Each strategy functioned to remedy different portions of the essential issue: that nurses' practice environment was changing and with it, nurses had to change as well.
Chapter 2

What’s in a Name? The Classification of Nursing Diagnosis, 1973–1990

In early spring of 1972, the Veterans Administration (VA) opened a new hospital in San Diego, equipped with all the latest technological tools to manage patient treatment needs. A parade of dignitaries and patients flooded into the hospital for tours and care. Patients previously housed at the U.S. Navy’s Balboa Medical Center were eager to begin their recovery, receive access to all the services offered at the new VA facility, and start new chapters in their lives as veterans instead of soldiers. The hospital boasted streamlined food service, a large laboratory equipped to process all the latest medical tests, and specialized patient rooms designed with bedside oxygen and high-tech patient monitoring equipment, as well as all the usual amenities. Situated next door to the University of California, San Diego campus, this new VA facility was a modern example of the best the U.S. could offer its veteran population.

The new facility’s selectively recruited medical staff boasted prominent physicians, some of whom were women and people of color. While the diversity of the medical staff may seem common today, in 1974 when the facility opened its doors such hiring practices were as progressive as the technology found throughout the hospital. Interestingly, what also accompanied this medical staff was a new category of worker. To staff this new category, the hospital hired eight nurse clinicians, followed by an

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126 Overview of Opening Day Activities, 14 March 1972, box one, unprocessed, VASDHS Facility Archives, San Diego, California.
128 Dedication, 14 March 1972, box one, unprocessed, VASDHS Facility Archives, San Diego, California.
129 Ibid.
additional six at the end of the first year of operation. These nurse clinicians, hired to perform various medical and nursing functions in clinics housed in the facility, were working in expanded roles, roles that were primarily negotiated between the hospital and the physicians and nurses who worked there.

This new worker conducted physical exams, ordered tests and treatments for a variety of patient conditions, and coordinated patient services, responsibilities that traditionally did not fall to the nursing staff. Some of the nurses hired into these positions held advanced degrees, while others came to the position with extensive clinical experience. Regardless of their previous preparation, these clinicians needed new skills, tools, and knowledge to fulfill the requirements of this expanded role. These nurses needed to be able to identify a variety of patient conditions, and were authorized to treat these conditions according to their individual clinical agreements.

This new category of worker, now known as a Nurse Practitioner (NP), was being developed across the country, not just in veterans' hospitals. While the VA took a fairly proactive position in hiring and creating a space for this type of nurse, NPs were being employed in clinics, physicians' offices, and hospitals across the country. And, just as the NPs at the VA had to negotiate the scope of their particular jobs, so too did the other

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131 Also see Fairman, *Making Room in the Clinic* for a discussion of the types of negotiations that occurred over practice responsibilities.
132 "Innovations." *Union Tribune*, 1973; Clinical Agreement Form (blank), VASDHS.
133 Clinical Agreement Form (blank), VASDHS; Nurse Clinician Job Description, VASDHS.
134 Fairman, *Making Room in the Clinic*. 
nurses in this type of role. The scope of the job was largely dependent on who these individual nurses were, who they worked with, and where they worked.

Despite the specific scope of a particular NP’s job, all NPs were being asked to adopt a complex technology essential to the care of patients: clinical reasoning.\(^\text{135}\) Clinical reasoning is the technology applied to patient care in order to identify patient problems, link a given patient presentation to a particular diagnosis, and make determinations about what treatment, if any, is needed.\(^\text{136}\) For NPs, the scope of application of this technology was broad, but there were restrictions. A nurse’s ability to overtly name the disease being treated, in the clinical record and in the form of a diagnostic statement, was something unique to each NP. In other words, the degree to which this clinical reasoning could be made visible in bureaucratic form varied based on the skills of the nurse, the level of collaboration between the nurse and physician, and the support of the facility. Each NP at the San Diego VA had a particular set of diagnoses that she was openly allowed to identify in the clinical record in areas of the chart previously restricted to physicians.\(^\text{137}\) However, the clinics and other settings where these NPs were assigned demanded that they know more and do more than what was bureaucratically recognized.

\(^{135}\) Why clinical reasoning? Why now? The reasons go back to the burgeoning expectations of patients that their nurse be able to answer questions about their medical conditions and that each nurse be capable of delivering skilled, knowledgeable care. This expectation was not isolated to NPs, but extended to nurses in general.\(^\text{136}\) Fairman, Making Room in the Clinic.

\(^{137}\) For the most part, some of these conditions were identified in the particular NP’s clinical agreement. Many, however, were subject to the process and product of negotiation between a given physician and nurse. Essentially, not all the ‘agreed upon’ diagnoses fell into the clinical agreement and nurses had to be able to respond to patient needs regardless of whether it was administratively sanctioned.
For many nurses, this lack of formal recognition of the NP's new role was a satisfactory arrangement, for it maintained the perceived status quo of technology transfer (from medicine to nursing), while safely and quietly expanding nursing practice.\(^{138}\) Yet not all were satisfied with this arrangement, and some sought out ways to change it. One barrier on this road to independence for NPs was the persistent notion that NPs' services should be differentiated from those of medicine. As Barbra Bates, noted physician and educator, explained to a graduating class of NPs at Cornell University, “By virtue of your having learned more medicine ... the patient may get less medicine, and less medicine, when mixed with more nursing, is probably better ... healthcare.”\(^{139}\) Bates aptly captured the complexity experienced by NPs in the course of their daily work—the challenge of straddling two disciplines, nursing and medicine, by way of application of similar skills, tools, and knowledge. The challenge was in taking the NP experience and translating it into bureaucratic terms that recognized and separated the services delivered by NPs from those delivered by physicians, a challenge Bates left to the individual NP.

However, there were those in nursing who were not satisfied with leaving individual nurses to deal with the flexibility and individual nature inherent in the NP's role. The following case examining development of the Classification of Nursing

\(^{138}\) This idea of technology transfer between medicine and nursing has been well established by other scholars and will not be reviewed here. For examples of this, see Ruth Schwartz Cowan, *More Work for Mother* (New York: Basic Books, 1983); Fairman and Lynaugh, *Critical Care Nursing*.

Diagnosis (CND) is an example of one group’s attempt to take on the challenge of differentiating nursing practice from that of medicine. Although this group’s approach was unique in many ways, in some respects it represented what was already occurring in hospitals, clinics, and physicians’ offices across the country. As discussed in chapter 1, the development of nursing care plans that contained a mix of diagnoses, signs, and symptoms of diseases were commonplace information practices being used by nurses. In a very real sense, these were practical tools that aided in the decision-making process and provided a means to manage the mix of nursing and medical interventions needed for a given patient’s treatment.\footnote{The nursing process consisted of five key elements: assessment, diagnosis, plan, intervention, and evaluation. The process was captured in nursing care plans that organized the data accordingly. Virginia Carrieri and Judith Stizman, “Components of the Nursing Process,” Nursing Clinics of North America 6, (March 1971): 115-124. For specific components, see Dorothy M. Smith, “A Clinical Nursing Tool,” American Journal of Nursing 68, (November 1968): 2384-2388; L. Mae McPhetridge, “Nursing History: One Means to Personalize Care,” American Journal of Nursing 68, (January 1968): 68-75; American Hospital Association, Nursing Care Plans (Chicago: Author, 1969); Helen M. Donovan, “Determining Priorities of Nursing Care,” Nursing Outlook 11, (January 1963): 44-45; Dorothy Smith, “Writing Objectives as a Nursing Practice Skill,” American Journal of Nursing 71, (February 1971): 319-320; Dolores Little and Doris Carnevali, “The Nursing Care Planning System,” Nursing Outlook 19, (March 1971): 164-167; Eleanor P. Lamberts, “Evaluating the Quality of Nursing Care,” Hospitals (November 1965): 61-66; Rita L. McGuire, “Bedside Nursing Audit,” American Journal of Nursing 68 (October 1968): 2146-2148; Maria C. Phaneuf, The Nursing Audit: Profile for Excellence (New York: Appleton-Century Crofts, 1972).} Also, care plans provided a way to maintain control over the messiness of clinical practice by providing order, while simultaneously illustrating nursing’s contribution to patient care.\footnote{For discussion about organizing practice, see D’Antonio and Fairman, (2004).} The nurses involved with developing the CND
believed there were elements embedded in care plans unique to nursing and set out to identify and extract them.\textsuperscript{142}

One of the most interesting aspects of this case examining the CND was the longstanding quagmire associated with nursing’s use of the word \textit{diagnosis}; in particular, nurses involved with creating this classification juxtaposed the masculine notion of diagnosis with the feminized practicality of nursing care.\textsuperscript{143} The planners of the first CND conference, the aim of which was to produce standard NDs, purposefully chose the term \textit{diagnosis}, despite the term’s significant social connotations, because the label reflected the enormous cultural authority intricately tied to the process of naming disease.\textsuperscript{144} Nurses involved with the creation of the CND were attempting to identify those particular patient problems that fell solely within the realm of nursing.\textsuperscript{145}

For CND conference planners, creating a nursing classification held a particular clinical utility that could assist in administratively clarifying the NP’s role. With the passing of the Medicare/Medicaid legislation in 1965, and subsequent amendments to that law in 1972, the future prospect of an independent billing system for NPs seemed

\textsuperscript{142} This notion fueled many discussions during the conference planning committee meetings. Minutes, Planning Committee, 7 March 1973; 4 & 25 April 1973; 22 May 1973; 6 June 1973, North American Nursing Diagnosis Association (NANDA) Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

\textsuperscript{143} Fairman, (2006); D’Antonio and Fairman, (2004).

\textsuperscript{144} Minutes, Planning Committee, 7 March 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

\textsuperscript{145} Minutes, Planning Committee, 7 March 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College; “Reflections on Nursing Diagnosis,” by Mary Ann Lavin and Kristine Gebbie, 8 May 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College; “More Reflections on Nursing Diagnosis,” Kristine Gebbie and Mary Ann Lavin, First National Conference on Classification of Nursing Diagnoses, no date, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
like a tangible goal—if their work could be made visible. This desire for visibility coincided with Congress's growing concern over the costs of the Medicare and Medicaid programs. One way in which Congress hoped to curb spending was by using nurses in new ways.

For others involved in nursing education and research, designing a classification system held other opportunities as well. Designing a classification system that was applicable to practice, but could also be used to facilitate programs of research and curriculum planning was appealing, but also complicated the design of the system. Regardless of the motives of conference planners and attendees, if the conference accomplished the goal of creating a CND, achievement of clinical autonomy was on the horizon for NPs. Superficially, this autonomy was about direct billing for services, but as the conference participants discovered, there was much more involved than economic freedom alone.

For an in-depth treatment of the economic issues surrounding healthcare during the twentieth century, see Stevens, In Sickness and in Wealth.

The interpretation by a large portion of nursing, and nursing administrators in hospitals was that the costing out of nursing services was vital if payment was going to be justified. This took two forms: direct payment to NPs and payment to hospitals for nursing services. The first had to do with nurses delivering medical treatment and being reimbursed for that treatment. Some examples of this discussion can be found in Cathryne A. Welch, “Health Care Distribution and Third – Party Payment for Nurses’ Services,” American Journal of Nursing 75, no. 10 (1975): 1844-1847; Paul Bergeson and Nancy Melvin, “Granting Hospital Privileges to Nurse Practitioners,” Journal of the American Hospital Association 49 (1975): 11-17. The second was a more diffuse, less focused initiative that attempted to account for nursing work done on behalf of a patient during a hospitalization episode. This took the form of patient classifications that ranked patients based on how sick they were and what type of technology was needed to sustain them. The initiative was diffuse primarily because each hospital developed its own measures. For an overview, see P. G. Giovannetti, Patient Classification Systems in Nursing: A Description and Analysis (DHEW Publication No. HRA 78- 22, Hyattsville, MD: Department of Health, Education and Welfare, 1978).
The Classification of Nursing Diagnosis, 1973–1990

In October 1973, the first conference on the CND was held in St. Louis, Missouri.\textsuperscript{148} Planners designed the conference as a series of work groups, discussion panels, and presentations aimed at producing NDs, as well as providing time to outline and address issues surrounding the process of classifying NDs.\textsuperscript{149} Nurses Kristine Gebbie and Mary Ann Lavin, with the assistance and work of a local planning committee, were responsible for calling the conference together. The majority of conference organizers were local to St. Louis, and many, including Gebbie and Lavin, were faculty members at St. Louis University School of Nursing. The school, along with Dean Marjory Gordon, supported the conference and provided many resources that helped bring the conference to fruition.\textsuperscript{150}

In addition to their faculty appointments, Gebbie and Lavin maintained clinical positions at St. Louis University Hospital. Lavin was working in an outpatient setting that mainly saw cardiac patients, while Gebbie worked in a psychiatric outpatient unit.\textsuperscript{151} According to Lavin, she and Gebbie were functioning as NPs to the extent that they were diagnosing and treating medical and nursing problems.\textsuperscript{152} Both asserted that they were seeing patients for different reasons than were their physician colleagues, but were unable

\textsuperscript{149} Minutes, Planning Committee, 22 May 1973; 6 June 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
\textsuperscript{151} Shortly after initiating planning for the conference, Lavin left St. Louis and moved to Boston in order to obtain a graduate degree in public health from Harvard University.
\textsuperscript{152} Mary Ann Lavin, March 25, 2005.
to clearly state and document those reasons in a manner that communicated their work clearly to hospital administrators.\(^{153}\)

The two nurses were under some pressure from hospital administrators to “state more clearly the reasons that some [patients] were receiving [primary] care from [nurses rather than physicians].”\(^{154}\) Adding to the pressure was the hospital’s recent adoption of automated record keeping and subsequent offer of “a number of digits for data storage” for nursing-specific information.\(^{155}\) This new form of record keeping was a significant opportunity to make visible the work of nurses (work that had often been left out of the record all together), but both Gebbie and Lavin were unsure of how to take advantage of it. Both believed they needed guidance and initially thought a system for classifying patient health problems might be the way.

The idea of developing a classification system for nursing was not new. In 1960, Faye Abdellah had proposed a system based on twenty-one nursing problems.\(^{156}\) These problems reflected a contemporary view of nursing practice at the time, focusing on common patient needs such as adequate nutrition and comfort. However, this classification system, or typology as Abdellah referred to it, did not resemble the practice environment in which Gebbie and Lavin worked. Their work as both clinicians and educators gave them a radically different perspective on what information and knowledge were needed for a classification system to be successful. Both believed the focus should be on discrete disease entities and patients’ responses to disease, rather than on patient


\(^{154}\) Ibid., quote on page 1.

\(^{155}\) Ibid.

problems that primarily addressed behavioral and environmental issues. This shift in orientation from problem to disease was a major change for nursing and reflected the expectations now being placed on nurses. In Gebbie and Lavin’s view, this new type of classification system was required if it was to resemble the practice emerging in outpatient settings.

Although the school and dean both supported this new type of classification and could have easily directed resources to create one that satisfied only local needs and demands, Gebbie and Lavin sought to bring together like-minded nurses from across the country to create a uniform classification system that all NPs could use across practice settings and geographic locations. According to Lavin, she and Gebbie were intimidated by the thought of calling a national conference that was not sanctioned by the American Nurses Association (ANA): “We [Lavin and Gebbie] were young, just turned thirty, and thought to ourselves: who are we to be calling a national conference? I mean, we were nobodies at the time, but we also knew it had to be done and no one else was doing it.”157 Moreover, both believed that gaining the ANA’s cooperation would be a long, drawn-out process. They thought that waiting for the ANA’s sanction would take too much time and jeopardize present and future opportunities; thus, despite reservation, the two began marketing the conference.158

The conference was advertised in the *American Journal of Nursing*, and Gebbie and Lavin made announcements at a variety of meetings, inviting those interested in

157 Mary Ann Lavin, March 25, 2005
158 Lavin offered no specific explanation about why she and Gebbie thought it would take so much time other than that the ANA was a large organization and the request would have to be brought through ANA’s hierarchy.
attending to send letters detailing their qualifications and areas of practice. The stringent screening was a response to resistance to the NP role among nurses such as Martha Rogers and Hildegard Peplau, two leaders in nursing and nursing education. According to Lavin, their vetting process of screening and inviting select participants was a strategic move, as both feared that nursing's elite would dominate the meetings and that such domination might not produce a system useful to practicing nurses. Both wanted to ensure that nurses holding similar positions to their own outnumbered other types of participants.

Nancy Melvin, a pediatric NP from Arizona and one of the invitees, was fairly unreceptive to the idea of creating a classification system specifically for NDs and declined to attend the conference. In her reply to Gebbie and Lavin she wrote, "There is no difference between a nursing diagnosis and a medical diagnosis and [your project] will create more communication gaps than currently exist." Melvin's opposition to the idea of creating a specific classification to represent nursing practice prompted a response

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159 Gebbie and Lavin made announcements at National League for Nursing and American Nurses Association conventions in the two years prior to the meeting for the Classification of Nursing Diagnoses.
160 While Peplau supported advanced education and practice for nurses, she championed the role of clinical nurse specialists, and cautioned against expansion of licensure. Expansion of licensure was something many NPs were pursuing. For an illustration of Martha Rogers position, see Martha Rogers, "Nursing: To Be or Not To Be," Nursing Outlook 2 (1972): 42-46.
161 There is no indication in the proceedings or archive material as to who were considered to be nursing's elite.
162 Invitation List, June 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
163 Nancy Melvin, Coordinator of the Pediatric NP Program, Good Samaritan Hospital in Phoenix, Arizona to Kristine Gebbie and Mary Ann Lavin, 13 February 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
from Gebbie and Lavin regarding the issue of separating nursing and medicine.\(^{164}\) The two attempted to argue with Melvin, asking if she was implying that "all statements of evaluation are found in medical diagnosis manuals."\(^{165}\) The question, of course, was rhetorical and solicited no response from Melvin. Yet Melvin had hit on one of the chief reasons some nurses and others invited to the conference declined to attend.\(^{166}\)

Despite Melvin's and other clinicians' objections, many nurses responded positively to the invitation. Moreover, because Gebbie and Lavin carefully selected and vetted the participants, just over half the conference attendees were practicing clinicians.\(^{167}\) However, despite their clinical affiliations, these were not your typical nurses. Most attendees held appointments in academic institutions, and over 80 percent held advanced degrees, with less than one fifth of the attendees prepared at or below the

\(^{164}\) Melvin's letter was so definitively against the idea of this classification, that it prompted the only reply to a rejection letter from Gebbie and Lavin. Kristine Gebbie and Mary Ann Lavin to Nancy Melvin, 19 February 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

\(^{165}\) Ibid.

\(^{166}\) For example, Barbara Bates and Lawrence Weed declined attendance. For Weed, the core of his idea about the problem oriented medical record (POMR) was to have one problem list for all disciplines. Supporting the development of a classification specific to one discipline would not be in-line with the POMR. That being said, Weed used and supported the identification of diagnoses that were associated with medicine, but again, it was a widely used tool and readily communicated patient issues. Bates, as discussed earlier in the chapter, opted to leave nursing's political issues to nurses. There were others of note who declined attendance, like Joan Lynaugh who was one of Bates' nurse colleagues. While there were discrepancies amongst the documentation available detailing who did and did not attend, there were approximately 50 who declined the invitation. Letters of Rejection, First National Conference on the Classification of Nursing Diagnoses, 27 June 1972, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

\(^{167}\) Invitation List, June 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College; Accepted Attendee List, September 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College; Gebbie and Lavin, eds., *Proceedings of the First National Conference*. 
baccalaureate level. The specialty affiliations were primarily psychiatric, maternal-child, and adult health. This demographic makeup did not reflect the educational background of the majority of nurses at the time and suggested that this was a far more elite, educated group, primarily academic in nature.

Perhaps because of this demographic breakdown, the planning committee still feared that potential power inequities could arise if work groups were allowed to form spontaneously. Using the objectives of the conference to strategically organize work groups, Gebbie, Lavin, and the planning committee, purposefully split up administrators, theorists, and educators amongst clinicians. The planning committee did so because they believed the theorists, in conjunction with the some of the educators, would attempt either to deter or redirect development of the classification into something that conformed to conventional notions of nursing practice, a practice that was dependent on following physician’s orders. Additionally, the planning group was concerned about the theorists taking over the production of NDs in favor of theory reinforcement. They worried that

168 Invitation List, June 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College; Accepted Attendee List, September 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
169 Invitation List, June 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College; Accepted Attendee List, September 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
172 In many ways the theorists’ work served as intellectual examples of nurses’ growing independence, but many of them did not see the expansion of nursing practice into areas of medicine as independence.
the diagnoses produced would simply reinforce a particular theory or theories that Gebbie and Lavin believed did not reflect the practice of NPs. Concern was also raised about the nurse administrators’ participation and the likelihood that they would attempt to limit the classification either to billable diagnoses or diagnoses that could be used by any type of nurse, not just NPs.

To avoid any of these issues, the planning committee determined ahead of time exactly what parameters would be used to generate diagnoses, limiting the focus to individual patient diagnoses (which was reflective of NP practice) rather than diagnoses on the level of family, community, or population. In addition, the committee preemptively assigned each work group one of ten body systems on which to concentrate, again, a focus that moved the group further into NP practice. This tight control was necessary if conference planners were to keep participants away from traditional notions of nursing care, something that no longer meshed with the realities of practice. All these parameters were strategic efforts to prioritize, organize, and promote creation of NDs intended for use by NPs practicing primarily in outpatient settings.¹⁷³

**Ignoring the Elephant(s) in the Room: Open Forum Discussions**

Right from the start, participants objected to the planning committee’s organization of work groups by body system, citing that the division was “limit[ing] the consideration of new approaches more appropriate to nursing” and that the disease-based

¹⁷³ The basis for this work format came from solicitations Gebbie and Lavin included in their invitations to clinician requesting invitees to send in whatever NDs were being used at their facilities. Karin Default, Oregon State Board of Nursing to Kristine Gebbie and Mary Ann Lavin, 8 May 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
approach chosen by conference planners “wedded the conference to a medical model.” This was a pushback by participants on the tightly controlled format, but it also hinted at what Gebbie and Lavin feared—dominance of the conference by nursing’s elite. The “new approaches” to which the detractors referred were a number of theories developed by academic nurses to delineate the discipline of nursing. These self-identified “nurse theorists” recognized the inherent possibilities of furthering their ideas if they could get conference attendees to design the classification around their particular theory. If they were successful, it guaranteed reinforcement of their view of nursing; if they failed, something new could emerge or a competing view could be reinforced. By design, however, the lack of networking time built into the schedule, combined with the detailed focus of the work groups, left little room for such maneuvering at this first conference, and participants were able to move forward with the initial framework set out by the planning committee.175

In addition to the issues raised about the conference format, there was a significant amount of discussion and confusion about what exactly was meant by a nursing diagnosis (ND). Gebbie and Lavin, in trying to avoid having the conference derailed before it got started, presented a paper entitled Reflections on Nursing Diagnosis on the first day, in the hopes of clarifying what a ND was.176 They defined a ND as a statement made by a nurse after an examination or assessment. “The nurse [makes a]
diagnosis when she says, after an encounter with a new patient, his nursing problem is _____."\textsuperscript{177} This definition was so vague that it did little to clarify the issue. While the term \textit{nursing diagnosis} had been used in the nursing literature since the 1950s, the definition of the term was not precise. Thus, the nurses at the conference created a mix of medical diagnoses and signs and symptoms of diseases in their individual work groups.\textsuperscript{178}

As part of the conference, a panel consisting of external stakeholders also took up the issue of diagnosis. The panel included one physician and representatives from three groups: the American Hospital Association (AHA), the Joint Commission on Accreditation of Hospitals (JCAH), and the American Medical Record Association (AMRA).\textsuperscript{179} The panel members expressed hesitation over nurses using the term diagnosis. While the panel acknowledged that no legal limitations existed concerning nurses developing their own diagnostic taxonomy and that, given the process’s description, \textit{diagnosis} was the logical term, they warned the CND about a damaging emotional response from physicians and the public.\textsuperscript{180} John Renner, the physician on the panel, suggested that either the word \textit{nursing} simply be dropped or participants consider

\textsuperscript{177} Ibid.
\textsuperscript{178} "Reflections on Nursing Diagnosis," by Mary Ann Lavin and Kristine Gebbie, 8 May 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College; "More Reflections on Nursing Diagnosis," by Kristine Gebbie and Mary Ann Lavin, First National Conference on Classification of Nursing Diagnoses, no date, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
\textsuperscript{179} Mary Converse represented the American Hospital Association; Lyla Nieder Baumer represented the Joint Commission on the Accreditation of Hospitals; Elizabeth Price represented the American Medical Records Association; Otto Page was originally slated to attend and represent the AMA, he cancelled just before the conference and was replaced by John Renner, a physician and faculty member at the University of Wisconsin-Milwaukee.
\textsuperscript{180} Transcript, Interdisciplinary Panel Discussion, no date, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
using the word *problem* instead of *diagnosis*.\textsuperscript{181} His concern was that the work of the CND would be ignored because of the possible interpretations associated with using the words *nursing* and *diagnosis* together. Moreover, Renner made the point that, given the increased push toward an integrated health record with systems such as Weed’s problem-oriented medical record, placing the descriptor *nursing* in front of the term *diagnosis* risked segmenting the medical record and (further) isolating nursing.\textsuperscript{182} The panel also suggested using established medical terms in defining diagnoses, rather than developing a new terminology.

As practical as Renner’s and the panel’s advice was, most conference participants did not welcome the suggestions. In a response directed at Renner, one participant retorted, “Physicians will have to understand our use of the word [*diagnosis*].”\textsuperscript{183} Renner had struck a chord related to what Gebbie and Lavin had discussed earlier in the conference: that the need for labeling ND was intricately tied to generating a “strong nursing identity.”\textsuperscript{184} Many nurses involved with CND asserted they were seeing patients for different problems than were physicians. For them, it was necessary to capture both that separation and the inherent power associated with the language and process of diagnosis.

\textsuperscript{181} The hesitation was not limited to just the panel. Many nurses were concerned about nurses diagnosing. See Fairman, *Making Room in the Clinic*.
\textsuperscript{182} Transcript, Interdisciplinary Panel Discussion, no date, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
\textsuperscript{183} Ibid., anonymous.
\textsuperscript{184} “Reflections on Nursing Diagnosis,” by Mary Ann Lavin and Kristine Gebbie, 8 May 1973, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
The panelists astutely pointed out key issues affecting development and future dissemination of this classification. The division of labor and communication structure of the medical profession at the time differed from the CND, which was idiosyncratic in terms of design and function.\textsuperscript{185} As was mentioned briefly in the excerpt regarding Veterans Administration NPs, in practice, nurses and physicians divided labor chiefly based on the characteristics of the particular physician, nurse, and facility. This ad hoc division of labor represented what was occurring across the country. Nurses were responsible for diagnosing, treating, charting, and billing (first in the VA system, and then in civilian facilities) for specific agreed upon conditions, while simultaneously having to address conditions for which they were implicitly accountable, but not overtly responsible. Those latter conditions necessitated a diagnostic statement from a physician rather than a nurse. Because work situations varied, this division of labor was not consistent across settings and therefore posed a significant challenge to the dissemination of any type of classification that was uniform rather than unified.

Adding to this problem was the language the nurses at the conference employed. Instead of using existing clinical language that was commonly understood across various types of healthcare settings, the nurses began to develop a different idiom within each ND. For example, instead of using “shortness of breath” or “labored breathing,” nurses labeled that symptom as ND impairment of respiration.\textsuperscript{186} Another example was the ND

\textsuperscript{185} Comment was made by Elizabeth Price represented the American Medical Records Association. Transcript, Interdisciplinary Panel Discussion, no date, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

depletion of body fluids, also known as dehydration.\textsuperscript{187} Impaired mobility was a particularly challenging ND, as it straddled several possible meanings in existing clinical language; it could be interpreted as hemiplegia, a type of paralysis that affects half the body and is commonly associated with strokes; paraplegic, impairment of motor and sensory function of the lower extremities commonly associated with spinal injuries; or even problems experienced after hip replacement.\textsuperscript{188} The JCAH representative felt that, although this “elite group of nurses” understood the language, the average nurse would not easily comprehend it.\textsuperscript{189} They, she felt, would fail to identify with the CND language and refuse to use the diagnoses in practice.\textsuperscript{190}

Adding to the discussion surrounding adoption of this classification system, the panel member representing the AMRA questioned participants about who would be responsible for keeping codes up to date and entering them into the automated system.\textsuperscript{191} Unlike physicians, whose diagnostic classification was wholly integrated into the healthcare system, information specific to nursing care was not.\textsuperscript{192} The existing system of care, skills, tools, knowledge, and even spaces were designed around medical language. The most serious challenge to the classification system was that nurses, physicians, and

\textsuperscript{187} Ibid., p. 64.
\textsuperscript{188} Ibid., p. 81.
\textsuperscript{189} Transcript, Interdisciplinary Panel Discussion, no date, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College; Also see Gebbie and Lavin, eds., \textit{Proceedings of the First National Conference}, quote on p. 35.
\textsuperscript{190} The vast majority of nurses at this time graduated from three-year training schools, without advanced education. Their training experience and their work environment differed from that of the nurse conferees.
\textsuperscript{191} Transcript, Interdisciplinary Panel Discussion, no date, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College; Also see Gebbie and Lavin, eds., \textit{Proceedings of the First National Conference}.
\textsuperscript{192} Transcript, Interdisciplinary Panel Discussion, no date, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
hospitals would have to substantially change the way they thought about patients if the CND were to be adopted into practice.

Despite the well-reasoned points made by the various panel members, the nurses of the CND believed that if they pressed on and created the ND, this new information practice would prove a remedy for the lack of visibility the nurses faced. ND, the nurses claimed, focused action on behalf of patients, increased nursing’s effectiveness in correcting patient problems, identified specific nursing interventions, and provided for evaluation and organization of practice. Nurses would be able to discuss patient problems in depth using a single vocabulary, thereby enhancing information exchange about patients (albeit only with other nurses). These benefits, the nurses concurred, would make the “specific contribution of nursing to healthcare ... more readily identified.” They believed that ND would clearly articulate nurses’ contributions, leading various stakeholders, such as hospital administrators and patients, to recognize the work nurses performed and would provide for the possibility of nurses receiving direct payment for their work.

100 Named, but Problems Lay Ahead

At the close of the first national conference for the Classification of Nursing Diagnosis, conference participants identified nearly 100 diagnoses. The ND list included items such as anxiety, depletion of body fluids, alterations in comfort level, lack of understanding, and respiratory distress. In an effort to formalize the structure of future

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194 Ibid., p. 23.
conferences and dissemination of the classification system, the participants formed a National Conference Group (NCG) headed by Marjorie Gordon.\textsuperscript{196} The NCG for CND was responsible for planning the second conference and developing strategies to promote the work of the participants. This newly formed group, which included original conference organizers Gebbie and Lavin, charged Gordon with coordinating publicity efforts for CND, planning future meetings, and testing the identified diagnoses.\textsuperscript{197}

In the time between the first and second conferences, Gordon conducted a research project testing the 100 diagnoses. Researchers directly compared CND diagnoses with patient experiences. Gordon designed this research project to gather feedback from practicing nurses regarding ND “in common use for identifying nurse-treated problems” and to gather the information each nurse collected for each label.\textsuperscript{198} The research, which included the participation of 28 agencies from across the country and 588 patients, generated over 2,300 diagnostic statements.

Also during this interim, many participants and original conference planners were busy promoting the work of the first conference. The trio of Gordon, Gebbie, and Callista Roy, a nurse theorist and conference attendee, presented a paper summarizing the accomplishments of the CND to a packed room at the 1974 ANA convention in San

\textsuperscript{196} Marjory Gordon was Dean of St. Louis University School of Nursing. Organizational Time Line 1973-1983, no date, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

\textsuperscript{197} Initial funding was from the St. Louis University School of Nursing, and as the group’s membership grew, funds were generated from dues. Minutes, Task Force on Modus Operandi, 8-9 February 1974, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

\textsuperscript{198} Data Collection Project, 2 April 1974, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
Francisco. Gebbie and Lavin requested that Roy start working with them and Gordon to establish a conceptual framework for CND immediately thereafter. Earlier in 1974, Gebbie and Lavin coauthored an article featured in the *American Journal of Nursing*, one of several articles published on the CND between 1973 and 1975.

Despite growing interest from the general nursing population, conference organizers knew that the issue of selecting a taxonomic structure for the CND was far from over. During the first conference, organizers kept tight control on discussion and work group composition, thus averting a public attempt by the nurse theorists and their supporters to shift the focus of the open forums away from development of diagnoses to that of frameworks. Unfortunately however, the tight control drove discussion of frameworks into other forums. In their informal work groups, nurse theorists and others, mainly the clinicians, began discussing method, a discussion that would influence the work of future conferences.

**Inductive, Deductive: The 2nd Conference of the CND**

The second conference of the CND was held in 1975 in St. Louis, Missouri with nearly 120 invited participants. Changes to the participant vetting process and growth

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199 Additional sessions had to be offered because of overwhelming attendee interest. Callista Roy, March 17, 2005. Roy had attended the first conference and was a panel participant. She also was one of several nurse theorists who had attended the first meeting. Members of the conference group also presented a “rap session” at the 1975 National League for Nursing Conference.


201 Participant List, February 1975, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
in the CND's popularity meant that only 36 of the original 100 attendees returned. While there is no material available in the archive explaining the change, it was likely due to individual attendee's financial restrictions or lack of interest. The conference participants were expected to pay their own way, and this likely limited who was able to attend. Moreover, Gebbie and Lavin, whose influence lessened after the formation of the NCG, were no longer able to mandate clinician representation as they had for the first conference. Now, they were only two of thirty-five individuals involved with making decisions about the style and format of the second (as well as the third and forth) conference. The result was a shift in demographics that saw an increase in the number of academic nurses and nurses who were hospital administrators.

The nurse administrators had a growing interest in the CND due to new regulatory standards. Early in 1973, the JCAH implemented a new requirement that mandated each hospital demonstrate evidence of nursing care delivered. While JCAH left the specifics up to each hospital, many in the industry interpreted this new requirement as a need for formal care planning. This regulation was a response to pressure from Congress to

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203 Compared to the NCG, the first planning committee was made up of 23 individuals, 16 of whom were nurses and all were local to St. Louis.
204 Participant List, February 1975, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
205 JCAH had formed several committees aimed at examining information practices at hospitals. The results of these committees, and eventual regulation, shifted the focus of clinician charting. See John Porterfield, “Joint Commission: Tougher to Please in 1971,” *American Journal of Nursing* 71, no. 1 (1971): 70-74; JCAH’s 1972 Accreditation Manual for Hospitals, Nursing Services Standard IV stated: “There shall be evidence established that the nursing service provides safe, efficient, and therapeutically effective nursing care through the planning of each patient’s care and the effective implementation of the plans.”
206 A formal care plan was one included in the record of care.
slow Medicare and Medicaid spending and account for the quality of the services rendered under the programs. The CND offered a ready-made solution for meeting this new regulatory requirement.

Despite changes to the CND conference participants’ demographic makeup, work groups remained central to the meeting’s format and focus. The intent of this second meeting was largely the same as the first: produce as many NDs as possible. Perhaps because of the pressure to generate NDs, planners eliminated the panel discussions that had been held at the first meeting and replaced these semi-open discussions with keynote speeches. This structural change to the meeting format was important because it eliminated the remaining space for public dialogue. And although it is unclear whether planners did this intentionally in an effort to limit open discussion, the result was disastrous.

Recall from the first conference that planners had halted public discussion of a theoretical structure for the classification system, instead asking participants to construct diseased-based alphabetical listings of NDs. This structure was seen as temporary and meant to be followed by the development of a permanent framework after a sufficient number of NDs had been identified. This approach came to be known within the conference as the inductive approach and was supported primarily by clinicians and faculty who were struggling to find a mechanism to teach this new role of NP to their students. Clinicians preferred the inductive approach because it not only reflected the way NPs were learning their expanded role, but also spoke to the larger expectations being placed by patients on nurses, including NPs. Patients expected nurses to be capable,
skilled, and knowledgeable about the diseases and issues patients faced. This meant that prescriptive, formulaic notions of nursing care no longer guided nurses’ decision making.

Nurse theorists at the conference saw this inductive approach as a considerable threat, for it meant that their particular theory might or might not be reinforced by this classification (depending on how it developed). Two waves of theorists who released their work in the 1960s and the 1970s were present at the conference. For them this was a critical time, as it was the beginning of the end of their unique status within the profession. Practice was changing, and the theories were no longer the only means for exercising nursing’s intellectual muscle. NPs could do so in practice in ways that the theorists could only imagine, but each theorist found a way to revisit this debate on inductive versus deductive in whatever work group she was assigned. Thus, the products emanating from these work groups were largely a mix of ND and arguments for what became known within the conference as the deductive method. The theorists and others who supported this method argued for selection of a framework first, and only then, proceed with classification efforts.

With elimination of all open forums and all but a few informal free periods at the conference, public dialogue was gone. Discussion and maneuvering occurred in work groups, creating a seemingly backroom atmosphere. Participants increasingly conducted the business of negotiating strategy and political aims within these groups instead of generating ND. The proceedings claim that thirty new diagnoses were identified at this second conference, but in many cases, those were simply diagnoses that had been

\[209\] Ibid.
reworded from the first conference. Regardless, the transparency that deterred this maneuvering in the first conference had disappeared.

**Your Theory, My Practice: The 3rd and 4th Conferences for the CND**

The third conference for the CND took place in 1978, three years after the second, with the fourth following in 1980. Attendance at the third conference was more than double what it had been three years earlier, but the proportion of clinicians dropped again, this time to less than 10 percent of conference attendees. Conversely, the number of faculty and administrators rose. International attendees increased, with large contingents from Canada and the Netherlands, and plans were underway for translation of conference materials into Japanese. The NCG was responsible for this increased interest, as they had worked diligently between conferences to raise the profile of the CND. In the interim between the second and third conferences, the NCG began publishing a newsletter that boasted over 1,400 subscribers and supported development of regional work groups that held conferences in the Northeast, West, and Midwest.

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210 The archive papers had little documentation emanating from the work groups other than discussions/presentations about frameworks. It appears that what occurred between the conference and the published proceedings was the clarification of existing diagnosis and the incorporation of those ND identified by Gordon’s study between the first and second conference. Essentially the proceedings and planners had to show that something occurred at this second conference.


212 The first Canadian conference on ND was held in 1977 in Toronto and drew 100 participants.

213 This was primarily accomplished through member dues.

Despite the ostensible success of the NCG's proliferation of the CND, the issue of method would not die and continued to plague the third and fourth conferences. Revisiting the issue of method, Gebbie, in a paper prepared at the third conference, expressed her dissatisfaction with the deductive approach championed by the nurse theorists. Gebbie recognized that the process of identifying diagnoses from practice was messy, perhaps even uncomfortable for some, but cautioned against bringing some sort of artificial order to the process. Gebbie's speech had a tone of desperation to it as she launched what can only be viewed as a preemptive attempt to deter the theorists from continuing to exert their influence. She stressed the value of group diversity, and, as evidence of the success of the inductive process, she pointed to the fact that theorists, clinicians, administrators and others worked collaboratively throughout the first and second conferences.

The struggle for control over the CND was not so much about practice, although it began with that focus. Now, it was about the theorists maintaining their special status within the profession. Earlier the National League for Nursing, an organization that accredited nursing education, had mandated curricula ascribed to a particular theory. This mandate did some damage to the ideas and the intended use of the works, changing


them to frameworks that functioned as prescriptive approaches to nursing education and care. The theorists saw the CND as an opportunity to position themselves, rather than theory in general, alongside this new paradigm.\textsuperscript{218}

Gebbie’s plea to keep the focus on practice was essentially too little too late; a year earlier, Roy convinced the NCG to approve an independent nurse theorist work group to work in the interim between the second and third conferences. This group consisted of several high-profile, powerful women in nursing education, each with her own ideas about labeling nursing practice. Each had developed a theory on nursing that either emanated from extensive study of nursing practice or was generated from research projects that directly observed nursing practice. Most of the women in this theorist group had not practiced in many years, and those who were involved with nursing practice did so in capacities other than actively caring for patients.

Gebbie and Lavin, the original conference leaders, felt that the nurse theorist work group was a mistake.\textsuperscript{219} Both believed that allowing special interest groups to form, even with monitoring by the NCG, would detract from the mission of generating ND for use in practice.\textsuperscript{220} Gebbie correctly believed that unity was critical to the long-term aim of implementing a classification system. She feared that splintering the focus and giving in to special interests would stratify participants, ultimately deterring nurses’ uptake of the

\textsuperscript{218} We can see this in the minority report issued at a later conference by Orem in response to the CND’s decision to choose a particular framework. Her report outlined an alternative schema remarkably similar to her theory.

\textsuperscript{219} It is unclear why the NCG conceded to Roy’s request. I can only infer that it was difficult to say no to this group of prominent nurses, even if saying yes might jeopardize the classification.

\textsuperscript{220} The theorist group was the only group to receive approval for splitting off from the main conference group.
classification system. There was a palpable sense that these theories held little clinical utility, particularly now that nurses’ responsibilities in these new NP roles outpaced anything formal education could offer. Moreover, many at the conference echoed what one administrator pointed out during the open discussion after Gebbie’s speech—“that nurses *liked* practicing with the medical model,” and anything else would ultimately hinder the nursing profession’s uptake of the classification system.

Roy, who had been appointed chair of the theorist group by Gordon and the NCG, extended invitations to twenty-one theorists; fourteen accepted and attended their first theorist group meeting at the 1978 conference. This meeting’s two key objectives were to develop a conceptual schema that fit the diagnoses being generated and make a recommendation for order of generality. To accomplish these objectives, theorists were

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221 Draft Manuscript, “Toward Theory Development for Nursing Diagnosis Classification,” 8 April 1978, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

222 This was of course nearly heresy to many of the nurses in attendance even though the clinicians practiced with this model. Part of socialization into nursing, then, as is now, entails reference to a continual belief that nurses who practice medicine, aren’t nurses. As ridiculous as it sounds, they are considered disloyal. However, what nurses were taught in their education, especially during this time period, was not preparing them for the work they were expected to do. The medical model was, and is, in fact a useful tool for managing the messiness of practice. For more on this, see D’Antonio and Fairman, (2004). Quote from: Summary of Open Session, 6 April 1978, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

223 There were 21 invitations sent out (no list available in the archive as to identify who Roy had selected). Nurse theorists and/or group members in attendance at the third conference were: Callista Roy (chairperson), Andrea Bircher, Rosemary Ellis, Joyce Fitzpatrick, Marjory Gordon, Margaret Hardy, Imogene King, Rose McKay, Margaret Newman, Dorothea Orem, Rose Marie Parse, Martha Rogers, Mary Jane Smith, and Gertrude Torres. Eleven of the original 14 returned for the fourth conference. These nurses were: Callista Roy (chairperson), Andrea Bircher, Rosemary Ellis, Marjory Gordon, Imogene King, Rose McKay, Margaret Newman, Dorothea Orem, Rose Marie Parse, Martha Rogers, and Gertrude Torres.

224 Prior to their first meeting the theorists divided the labels generated from the first and second conference into general categories and then attempted to establish a conceptual hierarchy of the knowledge generated. Three general orders of knowledge were
given all of the ND generated at the first and second conferences so that they could organize and create categories from the over 120 diagnoses. The expectation was that something new would be created, that clarity would be gained regarding various conceptual levels at which ND were being generated, and that this taxonomic structure would, in draft form, resemble nurses’ thinking about patients, albeit on an abstract level.

Returning to the open panel discussion format that had been eliminated in the second conference, the theorist work group presented the conceptual schema they developed.225 This schema consisted of eight terms with accompanying definitions.226 It is no surprise that none of the terms were new; in fact, all represented some conceptual tenant of an existing theory created by Martha Rogers, one of the theorist work group’s members.227 While transcripts of this panel discussion don’t depict silences, guffaws, gasps, or uttered sounds of surprise, one can imagine that all were audible as the audience of the plenary session received the schema with little enthusiasm. Participants hammered the panel with questions about their choices and the work they had supposedly completed. Most wanted to know why and how, after meeting for four days, the theorists chose to adopt an already-established theory, particularly one that had few adherents identified; empirical indicators, hypothetical constructs, and summary concepts. The work had progressed to this point when the theorist group held their first face-to-face meeting in 1978.

225 Theorists Presentation, Callista Roy, 8 April 1978, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
226 The terms were: synergy, entropy, negentropy, system, conceptual model, principal, unitary man, and environment.
227 This probably reflected the composition of the theorist group, most of who were Rogers’s adherents. Thus, it is no surprise that Rogers’s theory emerged from the work group, as she was a formidable force in nursing thought at the time. She described her theory as “a conceptual system intended to stimulate development of other nursing theories.” Summary of Theory Panel Discussion, Martha Rogers, Joyce Fitzpatrick, Margaret Newman, Dorthea Orem, 8 April 1978, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
outside the academic setting.\textsuperscript{228} The dialogue between clinicians and theorists grew argumentative at times, as the schema seemed to ignore practicing nurses. Many at the conference viewed the schema as a blatant attempt on behalf of Rogers and her supporters to promote her theory at the expense of the work of the conference.\textsuperscript{229}

However, not all the criticism came from audience members. Dorthea Orem, a member of the theorist work group, issued a minority report that outlined an alternative schema remarkably similar to her own theory.\textsuperscript{230} Orem, watching the clinicians’ unreserved rejection of the proposed schema, saw an opportunity to raise her theory as an alternative and couched her proposal as one that held clinical relevance for nurses. She supported the clinicians’ criticisms and added that “[Rogers’s theory of] unitary man does not consider \textit{in what way} nursing is concerned with [practice].”\textsuperscript{231}

Margaret Hardy, another member of the theorist work group, seemed taken aback by the forcefulness of the clinicians’ objections and remarked that “something happened” over the course of the four days, implying that Rogers’s political agenda had somehow hijacked the group.\textsuperscript{232} Others on the panel, such as Imogene King, also confronted Rogers.\textsuperscript{233} In defense of the schema, Rogers argued that the framework was not brought forth as a way to confirm her theory but rather to pull together the psychological, social, and physical attributes identified by the general work groups. But the participants were

\textsuperscript{228} Report of Group Discussions, 8 April 1978, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
\textsuperscript{229} All of the participants had to pay their own way in order to attend. This may have added to the hostility expressed toward the theorist group, as it was the impression of many participants that the theorist groups were wasting time.
\textsuperscript{230} Orem, a nurse theorist was working as a consultant for her firm Orem and Shields, Inc. Report of Group Discussions, 8 April 1978, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
\textsuperscript{231} Ibid.
\textsuperscript{232} Ibid. Margaret Hardey was an associate professor at Boston University.
\textsuperscript{233} Imogene King was a professor at Loyola University.
unsatisfied with Rogers's and other explanations offered by the panel and demanded examples of the schema's applicability to clinical practice.

In an attempt to avoid derailment of the entire process, NCG leader Marjorie Gordon directed the theorist group to work together with three clinicians to develop case studies that applied the proposed schema to clinical practice. This collaboration was to begin after the third conference, with results to be presented at the fourth. The collaboration was Gordon's attempt to bridge the growing divide between clinicians and theorists and force production of a taxonomic structure that could be backed by both groups.

Unfortunately, the collaboration did not occur at the level Gordon desired. The theorist group met four times after the third conference, but the three clinicians assigned to work with them, Lucy Field, Margaret Stafford, and Sylvia Weber, did not attend any of these in-person meetings. Roy, chair of the work group, commented that she considered the clinicians to be "more like consultants" than collaborators. The consultants were not used by the theorist group until just before the 1980 conference when evidence of the "collaboration" was needed. It seemed that, despite the vehement debate that ensued around the proposed framework, the theorists remained unfazed and did not feel pressured to take into account clinicians' viewpoints.

Roy began her portion of the panel presentation at the 1980 conference by commenting that the theorist group was "not together" as much as they should have

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234 Ibid.
235 Lucy Field was a clinical nurse specialist and a faculty member at Boston University. Margaret Stafford was a clinical nurse specialist in cardiac care in Northlake, Illinois. Sylvia Weber was a psychiatric nurse clinician in Cranston, Rhode Island. Lucy Field to Members of the Nurse Theorists Group, 20 February 1980, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
been. Roy was referring to the level of collaboration both within the group of
theorists and between the theorists and the rest of the conference attendees. Roy
acknowledged the distance between the theorists' stratum and actual clinical practice,
urging reconciliation between "two values highly important to ... all: the practice of
nursing and the development of the science that is basic to practice."238

Rogers took issue with Roy's acknowledgement that there was a separation
between theory and practice and called the notion a "myth."239 In Rogers's view, basic
research generated new knowledge that was applied in practice, and applied research
dealt with the knowledge already present in practice. Practice, according to Rogers, was
"the application and utilization of theory."240 Rogers continually stressed the applicability
of her theory to the diagnoses being generated and to all areas of practice. Unitary man,
the main tenant of Rogers's theory, represents her belief that patients (humans) are
energy fields in constant interaction with the environment. Rogers's theory has few
operational referents, making it largely irrelevant to practice.

The clinicians assigned to work with the theorist group did not display as much
optimism about the schema as did Roy or Rogers and took their opportunity to finally be
heard. Fields, one of the clinicians, disagreed with Rogers's assertion that the schema
applied readily to practice. Fields thought the biophysical aspect of the patient's response
to illness had been unduly limited, which would hinder application of the schema and

237 Callista Roy, "Historical Perspective of the Theoretical Framework for the
Classification of Nursing Diagnosis" (paper presented at the Fourth National Conference
on the Classification of Nursing Diagnoses, St Louis, Missouri, 1980), quote on p. 241.
238 Ibid. Roy provided a nice articulation of the chasm between nursing science,
education and practice.
239 Martha Rogers, "Development of a New Knowledge Base for Nursing" (paper
presented at the Fourth National Conference for the Classification of Nursing Diagnoses,
St. Louis, Missouri, 1980) quote on p. 247.
240 Ibid.
The proposed schema focused mainly on behavioral aspects of a patient's response to illness, with little attention paid to the patients' physical response. Fields stressed that further clarification of the concepts was necessary to facilitate clinical application. She also pointed out that the schema necessitated an ideal practice setting where nurses had time to apply the framework and address the issues identified, suggesting an incompatibility between the schema and reality of practice. Weber, another clinician working with the theorist group, agreed with Fields that application of the framework was time consuming. Weber added that application of the framework was dependant on the professional preparation and maturity of the nurse, and that those nurses with less education would have difficulty with its application.

Margaret Stafford, perhaps the most vociferous clinician in the group, pointed out that her interaction with the theorists was limited, inferring a lack of interest on the theorists' part in involving the clinicians in their work. She felt her clinical expertise had little influence over decisions made by the theorists and that the result was an abstruse taxonomic structure. Not only did she and the other clinicians feel frozen out, but the proposed schema seemed to have no clinical relevance, did not use the language

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241 The biophysical aspect Fields was referring to were things like blood tests or more sophisticated measures of disease and health status. Responses of Clinical Specialists to The Unitary Man Framework, 1980, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
242 Fields pointed out the in order to verify the framework, time-frequency studies would need to be completed. This was a concern because this required multiple assessments over time and would hinder not only application but also open up the potential for incompleteness in the patient's record. Another concern was the lack of discreteness in the concepts of unitary man. Failure to clarify these concepts would hinder data collection and data analysis, defeating the original purpose of the diagnoses, that of identification of nursing's contribution.
243 The majority of nurses practicing were graduates of diploma schools and not exposed to many of the theories discussed in the proceedings.
244 Ibid.
of clinical practice, and seemed to disregard the experiences of practicing nurses. Her dissatisfaction was evident as she commented on the framework identified by the theorist group. Stafford's own words best describe her level of frustration with the schema:

The characteristics of unitary man, however, do not describe or encompass the wholeness of the individual in his ecosystem. And the schema lacks the organizing threads inherent to a conceptual framework from which new nursing knowledge will flow. Philosophically, I reject the framework and clinically I find it ineffective, cumbersome, and time-consuming, a futile exercise in words and an exercise lacking in specificity. I believe it is unconscionable to propose a framework for nursing diagnoses that doesn't accommodate the foregoing crucial concerns of professional nursing.245

While it was clear that the clinicians assigned to work with the theorists were not uniformly in support of the framework, proceedings editor Mi Ja Kim, perhaps in an attempt to smooth over differences, stated that conference participants, on the whole, "were much more open to the framework and were willing to learn and relate it to their clinical practice."246 The framework, while not formally adopted, seemed to have taken root and had become embedded into the CND, even though it was unclear whether the theorist group would hold together much longer. Dissent amongst the theorists was growing; the politics of ego began to obscure the work envisioned by original conference planners. Production of new diagnoses further declined as discussions of the schema increasingly consumed work group sessions, and at the close of the fourth conference, diagnoses numbered just under two hundred.

245 Ibid., page 4.
246 Mi Ja Kim was an associate professor at the University of Illinois. Mi Ja Kim, "Summary and Future Recommendations," in Proceedings of the Third and Fourth National Conferences on Nursing Diagnoses eds., Mi Ja Kim and Derry Ann Moritz (St. Louis, Missouri, 1980): quote on page 381.
Interestingly, during this conference there were subtle changes to the intended audience of the CND even though the majority of debate centered on the framework proposed by theorists. Originally, the CND was supposed to provide additional education at advanced levels and be used by nurses taking on the new role of NP, a role that was requiring additional on-the-job training and transfer of skills and knowledge previously felt to be the domain of medicine. The CND was also meant to assist nurses in making visible the work they were doing and to facilitate direct billing for services and other administrative tasks. However, conference participants recognized that the classification was being used in ways that they themselves had not intended. Nurses with two-year degrees and diplomas from hospital training schools were starting to use the ND in practice without the schema.

Nurse administrators expressed interest in the CND as a means for meeting JCAH regulatory standards, and this influenced uptake of this classification in ways conference organizers had not imagined. The preoccupation with theory versus practice and inductive versus deductive, as well as the worries about undue influence of the elite, had little to do with how this information practice was actually being used. Nurse administrators and others started to apply the classification system to their formalized care planning activities now mandated by JCAH. The list of ND, currently offered by the CND group in alphabetical form, was combined with other site-specific ND and was fast becoming a documentation requirement.247

Derailment: The Lasting (?) Legacy of the Nurse Theorist

247 Administration Panel Discussion, 7 April 1978, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
In light of the happenings at the fourth conference, the format for the fifth meeting of the CND changed to include two tracks for participants. One track would be dedicated solely to the production and refinement of ND, and the second track would explore the taxonomic structure proposed by the theorists. This was a purposeful split because of the dwindling number of ND being produced as a result of so much conference time and attention being diverted to the framework. Participants who were in the second track were tasked with determining how existing or new labels related to the concepts identified in the framework. Twelve groups worked on developing labels, and one worked on the proposed framework.

Another change that occurred at the fifth conference was the structure of the organization. Conference attendees also formally adopted bylaws that had been written in the interim between the fourth and fifth conferences. The organization also selected and approved an organizational logo, changed its name to the North American Nursing Diagnosis Association (NANDA), and elected a board of directors. NANDA intended to foster the generation of ND and facilitate the dissemination of the classification. This change to a formal organization was prompted partly by the group’s growth, but also as a way to further informal attempts by Marjory Gordon, then chair of the NCG, to get the

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249 Small Group Assignments, Fifth National Conference, April 1982, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

250 Bylaws, 1982, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
classification acknowledged by the ANA. The NCG was finding it increasingly difficult to complete conference planning, publish the newsletter, provide general promotion of the CND, support regional work groups, provide oversight to the publication and editing of each year’s proceedings, and of course, review an increasing number of ND being sent by nurses (primarily faculty and researchers) to the NCG in the interim between meetings.

NANDA’s need for ANA recognition was prompted by the ANA’s issuing of its Social Policy Statement. The policy statement was intended to serve numerous functions for the ANA, functions that will be addressed in later chapters. For NANDA, the Social Policy Statement (SPS) renewed the organization’s sense of purpose. Norma Lang, chair of the ANA SPS task force, actively participated in NANDA. Editors of the NANDA conference proceedings commented that the SPS was the “one single force that gave a boost to the development of ND.” The policy statement called for “identification of phenome[na] of interest to nursing,” phenomena that attendees at this

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251 There was mention of the NANDA classification and the organization’s desire to be recognized as the group for sanctioning ND during informal conversations between Gordon and Norma Lang prior to both groups beginning formal negotiations. Norma Lang, personal communication, May 18, 2007.

252 The Social Policy Statement was a document outlining the ANA’s stance on the development of specialty nursing practice and practice in general. It outlined the organization’s plan on what initiatives would be acted upon, one of which was the identification and development of phenomena of interest to nursing. See American Nurses Association, A Social Policy Statement.

253 It also represented a potential threat to the work being conducted by NANDA. If the ANA decided to be the clearing-house for ND; NANDA would be challenged to continue its programs.

and previous conferences were working hard to identify. It was as if the work was, at least informally, recognized and sanctioned by the ANA.

Although the conference had a renewed sense of purpose, the outrage and disappointment felt by clinicians at the close of the fourth conference lingered. Conference planners had scheduled a series of paper presentations that refueled the debate, even though to a great extent, NANDA had abandoned their focus on advanced practice. One presentation in particular prompted a lively discussion on the issue of selecting a classification. Glenn Webster, a philosophy professor at the University of Colorado, Denver, gave a paper entitled *Nomenclature and Classification System Development.* In the presentation, he cautioned about premature closure of the work being done at the conference. In the open dialogue session that followed his speech, Jacqueline Wylie, a clinician and member of the audience, posed the following to Webster: “A lot of nurses have practiced from a very authoritative knowledge base that does not allow for change and flexibility. How do you help these nurses use a more tentative, open classification system?” He replied: “Famous Oxford Dons maintain that

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256 Lang used much of NANDA’s initial work on ND in the Social Policy Statement.
257 This change in focus was a slow, gradual shift brought on by losses in clinical membership. Additionally, the use of ND was now splitting into two camps: administrative and research applications. Administrators were using the ND to meet regulatory requirements mandating care planning activities and researchers were using ND as constructs.
258 Webster was also a member of the ANA SPS task force. He was the “linguistic consultant.” Manuscript, “Nomenclature and Classification System Development,” by Glenn Webster, 1982, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
what I do not know is not knowledge. Or reversing it—what I know is knowledge but what I do not know is not knowledge. There are a few elitists who support that position—it is a deadly potion in nursing right now, [especially because practice is changing rapidly]. I [fear] if you try to come up with closed categories prematurely ... you are wasting your energy.

Unfortunately, Dr. Webster’s comments fell on deaf ears. Revisiting the same arguments that erupted at the third and fourth conference, participants in another open session complained that the framework lacked clinical utility. Even members of the theorist group continued to attack the framework and each other, adding that the theory failed to follow the rules of categorization. Roy, who previously had not personally commented on the framework, added her perspective, pointing out that the reason Rogers’s theory was not functioning as envisioned was because the concepts had not been “empirically validated.”

Either this was a shrewd move by Roy, whose own theory was generated from a grounded theory study and could be considered empirically generated, or it represented a sign of Roy’s fatigue with regard to her chairmanship of the theorists group. Regardless, Roy opened the door to a rather frank discussion about the overall approach that some within the theorist group believed was needed to generate ND. Roy implied that existing ND would have to be reevaluated against the proposed framework, and only

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260 Ibid.
261 Summary of Theorists Discussion, 1982, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
262 Ibid. This was a quote from Roy.
263 Ibid. Also see Kim, McFarland, and McLane, eds., Proceedings of the 5th National Conference, quote on p. 42.
those that fit would be retained. The rest would essentially be set aside. This infuriated audience members, some of whom started to protest (incoherently in the transcript). Roy attempted to clarify, stating that "concepts need to be explored, explicated, and developed. That is the next stage down the road. But we do not want to stay at the abstract level, we do not want diagnoses to read, for example, ineffective exchanging; rather once we have totally developed the concept of exchanging there will be labels under that pattern." An unidentified responder from the audience retorted "I think you are counting your chickens before they hatch!" Roy replied, "Well that may be, but [the application of the CND] is something the clinician has to deal with."

She was wrong. Clinicians would not have to deal with it. While attendees busied themselves with debating development of the classification system, changes were occurring in healthcare that would influence current and future uptake of the CND. Powerful economic influences began shifting the way clinicians were charting and billing for services. The introduction of the Diagnostic Related Groups (mentioned in chapter 1) necessitated that hospitals and other healthcare entities justify the care they provided by demonstrating nearly all billable services rendered on behalf of the patient. These

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264 Summary of Theorists Discussion, 1982, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
265 Ibid., quote is from Roy.
266 Kim, McFarland, and McLane, eds., Proceedings of the 5th National Conference, quote on p. 43.
267 Ibid. Recall from the beginning dialogue about inductive vs. deductive approach to ND generation. The theorists wanted a framework identified first because then, a theory would be reinforced. It lessened the risk that a new framework, one that closely resembled practice would replace one of their own theories.
services for nursing started to take the form of itemized supplies and treatments, moving charting practices away from nursing care plans and back to treatment plans. The Kardex, a tool used by nurses to plan the activities and tasks associated with patient care, was more pragmatic than the lengthy nursing care plans discussed in chapter 1. Reduction of charting practices associated with nursing care was just starting and would continue to gain popularity, leaving the clumsy, obtuse CND on the shelf.

Moreover, the CND’s language was moving further and further away from the language used in practice. Warnings about the use of complex jargon, warnings that were cast aside in favor of other interests, now manifested in widespread rejection of the CND by bedside nurses. Because the CND authors utterly neglected to consider existing practice conditions, the classification was becoming less and less attractive as a potential information practice for organizations. Compounding the difficulties, the association of the CND with theorists was like an albatross for the organization, one that was not easily thrown off. Moreover, the CND was originally conceived with NPs in mind, and NPs now had other means, in the form of direct billing using medical diagnoses, of having their work recognized. Thus another opportunity for dissemination of the CND was

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closing off, further illustrating that Roy’s comment about clinician’s needing to deal with the application of the CND could not have been more wrong.

**Formalizing NANDA: The 6th Conference for the CND, 1984**

The sixth conference, held in 1984 and boasting 460 participants, and the first under the name NANDA, was most notably marked by the work of formalizing this newly formed organization. The board of directors, in the interim between the fifth and sixth conference, had appointed several committees. During the first business meeting, membership committee chair Anne Becker reported that there were 710 members of NANDA. While this was an impressive start, there were signs that interest in NANDA was waning. Becker reported that there were now only a little over one thousand subscribers to the newsletter, a drop of nearly four hundred from previous years.

Structurally, the work of the NCG was transferred to an executive director, Karen Murphy. Money was now being generated primarily from membership fees. She continued the organization’s day-to-day operations, essentially functioning as a clearinghouse for incoming ND and overseeing processing and publication of the newsletter. This new structure not only relieved NANDA members of some of the work needed to keep the organization running smoothly, but also gave the board of directors means to establish formal communication and collaboration with the ANA. Marjory Gordon, president of NANDA, initiated this process and, with the help of ANA

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271 Anne Becker was an associate professor at St. Louis University School of Nursing. Transcript of Business Meeting, North American Nursing Diagnosis Association, 5 April 1984, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
272 Ibid.
representative Norma Lang, once again sought formal recognition of the CND from the ANA. Lang, addressing all the NANDA members, explained that this liaison was through the ANA’s steering committee on classification of nursing practice phenomenon. The phenomenon of concern to nursing practice included ND, interventions, and outcomes. The ANA had formed this steering committee in 1982, just after the release of its SPS. 275

While at the conference, the two organizations seemed outwardly pleased about the agreement between the ANA and NANDA. However, the arrangement was not exactly what each had hoped for. NANDA initially sought to be the only group authorized to sanction ND for use in practice. Yet the ANA, under the guidance of Norma Lang, acting chair of ANA’s Congress for Nursing Practice, and Ada Sue Hinshaw, chair of ANA’s Council on Research, steered clear of this uniform approach

273 The letters outlining and negotiating this agreement span approximately a one-year period beginning in September of 1982 and concluding, for the purposes of solidifying an initial agreement in December of 1983. The correspondence included ANA staff member Irma Lou Hirsch, Marjorie Gordon of NANDA, and Norma Lang and Ada Sue Hinshaw, Co-Chairs of the Steering Committee on Classifications. The letters can be found in the Irma Lou Hirsch, Norma Lang, and NANDA collections. Irma Lou Hirsch, Program Coordinator to Marjorie Gordon, Chairperson, NANDA8 September 1982, Irma Lou Hirsch Papers, Private Collection, Author; Marjory Gordon, Professor, Boston College to Norma Lang, Ada Sue Hinshaw, Co-Chairpersons, Steering Committee on the Classifications for Nursing Practice 4 November 1982, Irma Lou Hirsch Papers, Private Collection, Author; Marjory Gordon, President, NANDA to Norma Lang, Chairperson, Steering Committee on Classification of Nursing Practice Phenomena, 9 December 1983, Irma Lou Hirsch Papers, Private Collection, Author. 274 Norma Lang, “Classification, Taxonomy, Structure,” in Classification of Nursing Diagnoses, Proceedings of the 6th National Conference ed., Mary E. Hurley (St. Louis: The C.V. Mosby Company, 1986). 275 The steering committee was responsible for identifying phenomena of concern to nursing. At the time of this speech the ANA was polling its structural units for possible ND classifications. 276 See FN 273.
because there were other groups and individuals involved with identifying ND for specific areas of practice. Home health and community settings were having difficulty with the mostly acute care focus of the CND, and consequently started to create ND more applicable to their areas. Choosing NANDA, or a uniform classification system, would not support identification of new NDs.

For their part, the ANA had requested that NANDA members serve as resources to the practice divisions of the ANA. In turn, the ANA would appoint a person from each of its clinical units to coordinate identification of phenomena with the respective NANDA committee. Such an arrangement, however, would subvert NANDA’s growing recognition as the primary organization for the generation of ND, so NANDA had it stripped from the agreement. The ANA did not pursue this further, and in the end, the initial collaboration was set up to be no more than an information-sharing mechanism between the two groups. This unusual compromise for the ANA was owing to financial constraints that limited any initiative the ANA pursued.

The structure of the sixth conference was much changed as well. This time it took on the more formalized milieu of a research conference. The small work group sessions were temporarily eliminated while the organization’s committee structure set up new policy and procedures for evaluating the framework and ND. Two new committees,

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277 The Omaha system and another created by Virginia Saba were two of the more popular systems.
278 See FN 273.
279 Hurley, ed., Proceedings of the 6th National Conference. There were thirteen invited papers presented at general sessions, six breakout sessions with papers that had been formally reviewed and accepted by the planning committee, and a poster exhibit. Special interest groups and regional groups met during the conference, and the organization handed out the first awards it had ever given.
the Taxonomy Committee and the Diagnostic Review Committee, were both chaired by Phyllis Kritek who stressed during her committee reports that the taxonomic structure had yet to be selected.\textsuperscript{280} What organizers had done was use NANDA's restructuring into a formal organization as a means to reevaluate all decisions, diagnoses, and proposed frameworks that had been made or identified prior to approval of the by-laws. This was a necessary move that halted, but did not stop, the theorists' growing influence over the development of the CND.\textsuperscript{281}

The remaining papers and reports were rather uneventful, although two points of interest did arise in a small yet significant special interest group report given to all members at the business meeting.\textsuperscript{282} This interest group was examining the CND for possible integration into the SOAP charting format.\textsuperscript{283} Clinicians most often used this charting format when the patient had a particular complaint that necessitated some sort of intervention or action. The special interest group report highlighted issues that might arise if the CND were integrated into SOAP. The primary problem was that nurses were using medical diagnoses in the assessment (A) section of the note. The use of medical diagnoses in the assessment (A) section of the note, followed by a plan (P) to alleviate that particular problem.

\textsuperscript{280} Phyllis Kritek was an associate professor at the University of Wisconsin-Milwaukee School of Nursing.
\textsuperscript{281} While many of the theorists attended this conference, their influence was waning and was reflective of a larger retreat from the use of nursing theories.
\textsuperscript{282} Report, Special Interest Group, 1984, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
\textsuperscript{283} The clinician would collect information about a patient's complaint, dividing the information into either subjective (S) or objective (O) information. The subjective section of the note contained things such as the patient's report of pain or dizziness, essentially things that could not be directly measured by a clinician, while the objective information section contained things such as blood pressure, heart rate, or respiratory rate. Once the clinician had collected enough information, identification of the patient's problem would be made in the assessment (A) section of the note, followed by a plan (P) to alleviate that particular problem.
diagnoses made sense, of course, because this information practice was widely understood by a number of disciplines, was integrated into the thinking routines of nurses, and effectively communicated issues being addressed by the staff. So even though the nurses’ findings were not within their formally recognized practice boundaries, they still had to find a way to communicate the information. Using the assessment section of a SOAP note allowed nurses to communicate via diagnoses, but in a part of the chart used for daily operations or the process of care, not for formal bureaucratic means.

This special interest group had stumbled on another issue related to dissemination of the CND. The patient issues that nurses addressed were not communicated in the CND in a way that was commonly understood. This was not only an issue of dissemination; if the CND were to be adopted, how safe was this communication practice? Remember that a large number of practicing nurses had little education above the associate degree level. The CND was becoming increasingly obtuse, particularly after the theorists had affixed their beliefs to it, and the language was moving further away from the language of practice. For example, the first iteration of ND “self-care activities, altered ability to perform” had evolved to “self-care deficit: feeding, bathing/hygiene, dressing/grooming, toileting” with six etiologies and four subsections, each with their own set of defining characteristics.\(^284,\)\(^285\) Moreover, many of the ND cross-listed other ND as etiologies. Now, if nurses were to use the CND as intended, they not only had to learn the language of the ND, but also all the subcategories and defining characteristics. This did not bother some involved with the CND; to them, it was a logical progression of the development of


not only the classification, but also nursing as a research-intensive discipline (an intensity that was not common in most places).

However, many NANDA members, despite the fact that the majority of their activities were not related to practice, still held onto the idea that the CND was primarily a classification for use in practice, and this was the second point of interest brought up at the conference. Interestingly, what emerged in bits and pieces during the business meeting, breakout sessions, and formal conference presentations was the question of whose practice this classification was intended for. Was it intended for use at the bedside in hospitals as means for achieving regulatory compliance, as the administrators who attended earlier conferences had thought? Or was it intended for use by nurses practicing at a different level, specifically NPs, as early conference organizers believed?

In Mi Ja Kim’s keynote address, she stressed that the CND was a language “unique to nursing—all of nursing.” Yet, later in her speech, she delineated where the CND should be used. She began by noting that nursing interventions can be divided up into three eras: pre-1960s, when functions of the nurse were predominantly dependent on medical direction; post-1960s, when nursing actions were a mix of dependent and interdependent functions; and post-1980s, when nursing actions or “the so-called fuzzy diagnosis [would] become clear and focused in the nursing domain.” Adding to this, she stated that there was wide disagreement about the appropriate level of independence a nurse should have, and that this level of independence varied with the nurse’s area of

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287 Ibid., quote on p. 8.
practice. She gave as examples cardiac intensive care nursing, where nurses were able to make treatment decisions and were largely independent, and floor nursing, which was more dependent.

Kim and other participants at this conference were starting to realize that they were not in control of the dissemination and use of the CND. If the CND was going to be applied at all, it would be used in areas where it made sense; that is, where the existing practice or education structure mirrored the structure and language of the CND. But, because of the design of the system, it was difficult to imagine where the CND might be applied. Unfortunately, although NANDA members were beginning to recognize their lack of control, they did little to change their approach to the developing the CND. Instead of realigning their work processes around their stated goal of developing a classification for use in practice, they continued to develop the classification to suit the needs of research and education.

After the close of the sixth conference, the board of directors and various committees of the organization began addressing some of the persistent problems facing NANDA. They considered the issue of image, particularly as it related to membership demographics and what type of clinicians used ND. Board members discussed their growing concern that the CND was primarily associated with theorists and research rather than practice.\textsuperscript{288} Despite these concerns, the Diagnostic Review Committee revisited the

\textsuperscript{288} I think it is important to note that the language describing who should use the classification changed. Early on during the first three to four conferences, the designation of the specific type of nursing practice—the practice of NPs—was made. Now, however, when referencing practice, it was more generic, less specifically about NPs and more about some generic idea about nursing practice. Minutes, NANDA Board of Directors
discussion of what type of user limits should be placed on the CND. In the archival
papers documenting the early formation of the Diagnostic Review Committee, one
unsigned note stressed the importance of “clearly defining the roles and expectations of
each nurse.” The note went further, stating, “We must take a definite stand as [to]
WHO should be making these decisions.” Clearly, there was bias about who should be
using ND, but more important, who should be identifying ND. The Diagnostic Review
Committee designed the ND submission policy to weed out nurses unfamiliar with the
CND format. While nurses could certainly learn the ins and outs of the submission
process, the important point here is that practicing nurses would have to be familiar with
a language that was nothing like how they communicated at work.

The members of NANDA, again predominantly an elite group of nurses, were
subject to other organizations’ attempts to gain control over changes occurring in
practice. The ANA had revisited the issue of entry into practice, an issue that split
nursing practice into two forms, technical and professional. This splicing of nursing
into educated and uneducated, or not educated enough, certainly reinforced the
established idea of classes of nurses. Foolishly, and perhaps again because the NANDA

Meeting, 10-11 May 1985; 8-9 December 1985, NANDA Papers, unprocessed,
Manuscript Collection, Burns Library, Boston College.
289 Note, Diagnostic Review Committee Communication, no date, NANDA Papers,
unprocessed, Manuscript Collection, Burns Library, Boston College.
290 Ibid. (original emphasis).
291 Technical referred to nurses who had two years of nursing education and professional
referred to a baccalaureate or higher. Entry Into Practice (An Outline Brief), prepared by
B.J. Badertscher, 24 April 1980, Lorraine Freitas Papers, Private Collection, Author;
Report, Scope of Practice for Technical ad Professional Nursing, June 1986, Lorraine
Freitas Papers, Private Collection, Author; Report, Grandfathering of Licensed Practical
Nurse/Licensed Vocational Nurse to Associate Nurse, June 1986, Lorraine Freitas
Papers, Private Collection, Author.
membership was primarily drawn from the same elite group as the leadership of the ANA, NANDA picked up efforts to differentiate themselves and the CND from what could be considered typical bedside nurses with two years or less education. The problem, again, was that nurses who were using the CND outside of NANDA were staff nurses who were mandated by JCAH to document a plan of care. Alienating this group of nurses would further compound difficulties with dissemination and uptake of the CND.

The (Not So) Great Debate: The 7th and 8th Conferences for the CND, 1986–1988

The taxonomy committee, in the time between the sixth and seventh conference, had placed each approved ND into the framework the nurse theorist work group had previously identified. This version of the CND, based on Rogers's Theory of Unitary Man, was called Taxonomy I and consisted of ND “grandfathered” in under an expedited reviewed by the committee. The committee released Taxonomy I to conference participants for review and comment at the seventh conference. Disputes over the taxonomic structure flooded into the business meeting, where a debate erupted once again over the framework. Although unnamed members made several attempts to carry motions

\[\text{\underline{292}}\] This was done with some debate within the taxonomy committee. The group debated the structure as well, but in the end placed the diagnoses into the framework and prepared the taxonomy for distribution to the membership. Frameworks Suggested as Methods of Categorizing and/or Ordering Data, no date, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College; Diagnoses Submitted for Review, no date, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College; Diagnosis, Group 1 (by entry into taxonomy), no date, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College; Diagnosis, Group 3 (by entry into taxonomy), no date, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

\[\text{\underline{293}}\] Memo, Karen Murphy to NANDA Board of Directors, 1 March 1986, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College; Draft, Taxonomy I, 1986, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.
to adopt Gordon's framework in place of Rogers's, these motions were ultimately defeated.\textsuperscript{294} Despite the rather intense debate against both Taxonomy I and the use of Rogers's theory to organize the ND, the membership approved it with some riders that necessitated revision by the taxonomy committee.\textsuperscript{295}

The business meeting progressed and an unidentified member made another controversial motion to restrict the use of ND to nurses who were bachelors prepared or higher.\textsuperscript{296} Though this motion was defeated, the membership proposed an alternative motion, one that could be seen as equally divisive. This motion had NANDA go on record as supporting the concept that only RNs are accountable for ND; it was passed with little debate. All the debate and motions were oddly self-important and were reflective of the lack of understanding of the general acceptance of the taxonomy.\textsuperscript{297}

Despite the failed motions to change the taxonomic structure, debate resurfaced at the eighth conference where several subgroups were formed to analyze the usefulness of

\textsuperscript{294} Minutes, Biennial Business Meeting, 11 March 1986, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College. Gordon’s framework consisted of 11 health patterns to organize ND. For example, elimination pattern dealt with patient issues like constipation or diarrhea. See Marjory Gordon, \textit{Nursing Diagnosis: Process and Application}, (New York: McGraw-Hill Book Company, 1982).

\textsuperscript{295} The revision was released a year later; see NANDA, \textit{Taxonomy I with Complete Diagnoses} (St Louis, MO: Author, 1987). The taxonomy committee comprised Phyllis Kritek, Susan Fowler, Lois Hoskins, Mary Hurley, Mary Kerr, Winifred Mills, Barbara Rottkamp, and Judy Warren. This committee would transition to a new one at this conference.

\textsuperscript{296} Minutes, Biennial Business Meeting, 11 March 1986, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

\textsuperscript{297} Again, nurses at the bedside used either the entire list or portions of the list as a means for meeting a JCAH regulation. Nurse administrators were using the taxonomy as a cookbook of sorts for developing plans of care. For example, the VASDHS second computerized nursing information system was the production of generic, standardized care plans. NANDA ND lists were used as the basis for these generic care plans.
Taxonomy I. Of these subgroups, two proved to be quite interesting: Clinical Usefulness, and Ideology. Right from the start, participants in the ideology subgroup pointed to the framework’s lack of clinical utility, citing their own practice as their primary means for rejecting the taxonomy. An unnamed participant attacked the framework, pointing out the lack of clinical experience the theorists had: “I think I am in the minority here, but I’ll say it anyway. I actually deliver patient care to real patients, regularly. I prefer to assess my patients based on Gordon’s FHPs [functional health patterns]. I know them. They are useful.” Another individual continued: “The words [in Taxonomy 1] are meaningless—and real nurses don’t use [them]. No one is so attached to ND that they would notice if you changed it.” Many participants questioned the theorists’ connection to ND, citing that “the work of the nurse theorists is really not reflected in popular writings on [nursing diagnoses].”

This last comment was in response to Rogers’s open questioning of the usefulness of ND. A participant went further, suggesting that Rogers was actually purposefully disrupting the work. She stated, “A few theorists do not hesitate to say they do not

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298 The board of directors felt it was important to revisit the discussion at the 8th conference. Minutes, NANDA Board of Directors Meeting, 20-21 February 1987; 15-16 May 1987; 19-20 June 1987; 10-11 August 1987; 14 March 1988, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College; Minutes, Biennial Business Meeting, 8 March 1988, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

299 Summary of Subgroup Comments, Taxonomy Issue- Usefulness, 1988, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College; Summary of Subgroup Comments, Taxonomy Issue—Ideology, 1988, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

300 Summary of Subgroup Comments, Taxonomy Issue- Ideology, 1988, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College (original emphasis).

301 Ibid.

302 Ibid.
believe in ND [generated from practice]. I sometimes feel that the human response model is a Trojan gift. This is a very harsh comment, but when one looks at the origin of the development of the human response model, one has the feeling that the process was one of accommodation rather than induction.\textsuperscript{303}

The comments came from an increasing sense of frustration from an ever-shrinking group of clinicians. They felt that "... lip service [was] being given to the grassroots nurses, (i.e., the staff nurse). If the staff nurse was important, the developers of the taxonomy would \textit{NEVER} have considered an organizational framework so ambiguous and meaningless."\textsuperscript{304} In an apparent last-ditch effort to change the direction of the taxonomy development, an audience member at the Clinical Usefulness Subgroup made the following plea, hoping to solicit adoption concerns: "Who decides what is clinically relevant for whom? Staff nurses have to buy into it now, not just [nurses with a] BSN."

Yet another exasperated participant asked, "What happened to the practice-driven nomenclature?"\textsuperscript{305}

What happened was that nurses who were clinicians left the organization. The current membership consisted mostly of researchers and teachers of nursing. The clinician ranks had dwindled and were practically nonexistent. Those clinicians who continued to participate had one foot in academia and one in the clinical world, some as

\textsuperscript{303} Rogers had made her opinion known in: Rogers, (1972). Quote from: Summary of Subgroup Comments, Taxonomy Issue-Ideology, 1988, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

\textsuperscript{304} Anonymous quote. Summary of Subgroup Comments, Taxonomy Issue-Clinical Usefulness, 1988, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College (original emphasis).

\textsuperscript{305} Ibid., anonymous.

\textsuperscript{306} Ibid., anonymous.
actual clinicians, but many as clinical instructors. In a survey of former members, the clinicians voiced their reasons for leaving the organization. Many were dissatisfied with the constant political maneuvering of the theorists, but most described a lack of clinical utility of the CND.\(^{307}\)

**Conclusion**

It is unclear what the organization did with the data collected from the member survey, although it seems the data were used more as confirmation of where the organization was at the time than as actual fodder for long-range planning.\(^{308}\) At the ninth conference, little mention was made of the changing demographics. The political upheavals, it seemed, had subsided as participants settled into the business of running the organization.\(^{309}\) NANDA had been approved by the ANA as the sanctioning body for ND

\(^{307}\) The board was aware of the decline in clinical members. Minutes, NANDA Board of Directors Meeting, 9-11 July 1988; 28-20 January 1989; 22-24 July 1989; 20-22 January 1990, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College. Here were some of the comments from former members: “Stop trying to overcomplicate things”; “[the] organization does not care about the bedside nurse”; “[the] organization is dominated by popular people”; “[the organization] needs to limit political factors as much as possible and function as a professional organization rather than a club”; “[I did not agree with the work done”; “[I am] disillusioned with NANDA’s changing criteria for consideration of ND”; “[NANDA is] too rigid, focused on taxonomy not [diagnosis]”. Member Survey Results, 1988, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

\(^{308}\) Minutes, Biennial Business Meeting, 15 March 1988, NANDA Papers, unprocessed, Manuscript Collection, Burns Library, Boston College.

and began formalizing its role by working with the ANA and other nursing organizations as they sought to have their ND approved.  

From the outset, the design of the CND was incompatible with the existing system of clinical care, a system that was designed and organized around a classification of disease or specific forms of disease treatment. For instance, a patient admitted to the hospital, depending on his or her particular problem, might be assigned to coronary care, medical/surgical, psychiatric, or perhaps a specialized treatment unit such as dialysis or chemotherapy. In abandoning the language used to explain patient issues in practice that was commonly understood across disciplines, the CND faced several challenges. The major issue, of course, was that the general communication structure used in medicine and nursing was based on disease classification. It was, and remains, how patient issues are transmitted in a given organization. Changing that communication structure, particularly to one that was confusing, clumsy, discipline-specific, and nonintuitive, simply did not make the CND a viable alternative.

Moreover, the CND was wholly dependent upon context if it was to be understood. The accompanying medical diagnosis and defining terminology for the ND

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310 Chronology and Notes on Meetings of Staff Task Force on Classifications for Nursing Practice, August 1987, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee; Summary Report of Meeting Outcomes, NANDA/ANA Collaborative Group on Taxonomies/Classifications of Nursing Diagnosis, 15-16 May 1987, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee; Recommendations to Organizational Boards, NANDA/ANA Collaborative Group on Taxonomies/Classifications of Nursing Diagnosis, 15-16 May 1987, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee; Cabinet on Nursing Practice to ANA Practice Councils, 13 January 1988, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee; ANA Policies Related to the Development of a Classification System, 3 March 1989, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
were absolutely necessary if the CND was to be used and understood in clinical terms. This meant that even more information than was currently collected had to be written up in order to understand the same problem. Recall the example of the ND impaired mobility. Alone, the diagnosis means the patient has an issue with movement, but without the accompanying medical diagnosis, it is difficult, if not impossible, to understand what exactly the patient problem is, and how and where the problem should be treated. The example illustrates how the existing system of care and the newly proposed CND could not be integrated, at least not without dramatic changes either in practice or in the language used in the CND.

Ignoring how practice was structured was an odd direction to take for nurses associated with the CND, particularly in light of their choice to use the term *diagnosis*. On the one hand, using this term was a way of recognizing the CND’s importance and the desire to have the classifications integrated into the existing systems of care. On the other, the CND highlighted divisions of labor that artificially separated what nurses and physicians were responsible for in the course of delivering care to patients. Using the term *diagnosis* was an attempt to prioritize this classification system and promote the emerging practice experienced by NPs, but creators again ignored this practice in which medical diagnosis and clinical reasoning were regularly used.

Since the 1990s, the CND has undergone numerous revisions. In 2002, NANDA released Taxonomy II with an updated structure that included material on classifications for nursing interventions and outcomes. The production of ND continues to be primarily a research effort by members of NANDA and is aimed at delineating a knowledge base for the profession. Clinically, the use of nursing care plans remains a staple regulatory
practice for nurses, and ND continue to be the focus. NANDA does not lay claim to wide spread use of the classification, and its current strategic plan reflects the organization’s ongoing efforts to generate support for its work. And, just as they did over thirty years ago, the nurses involved with NANDA define their mission thus: “The future of nursing practice is in our hands. It's up to us to define our own work. We need to make sure that the important judgments we make and the language that expresses them are deeply valued. That's what NANDA International is all about.”

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311 Membership dues and profit from conference proceedings sales fund the work of the organization.
Chapter 3


“The [American Nurses Association] has historically been responsible for defining nursing.”

American Nurses Association, Board of Directors, December 1987.313

During the 1980s, nurses, particularly those involved with the North American Nursing Diagnosis Association (NANDA), were developing an information practice for use in nursing. NANDA was working on this for many reasons, but in general the group was trying to fill a void in health information that largely ignored nursing practice. Surprisingly, the American Nurses Association (ANA), rather than leading this process, was relatively absent from the forefront of this area. Although the ANA’s lack of participation may seem odd, the organization abdicated its role as the profession’s foremost interest group simply because its attention was diverted internally to its own problems. The group was experiencing significant challenges to its viability. In particular, membership was dropping, in part because of the shifting needs of its members, many of whom left to join one of the emerging specialty organizations.314

313 Minutes, Board of Directors, American Nurses Association, December 1987, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
314 This was a gradual, steady drain on the membership. Minutes, American Nurses Association, Board of Directors, 22, 24-26 April 1972, Box 496 F3, 1-3 May 1973, Box 496 F4, 29 January-2 February 1974, Box 496 F6, 29-30 January 1975, Box 496 F8, 28-30 January 1976, Box 496 F10, 17-20 February 1977, Box 497 F4, 15-16 February 1978, Box 497 F8, 28-31 March 1979, Box 498 F5, 10-12 December 1979, Box 499 F1, 28-31 March 1980, Box 499 F2, ANA Board of Directors Meeting, ANA Papers, History of Nursing, Howard Gotlieb Archival Research Center, Boston University. Also see Lorraine Freitas, “Evolution of the Professional Nursing Organization Development of Power,” Ph.D. diss., (The University of Texas at Austin, 1986).
These specialty groups were forming in response to a growing need for education in specific areas of expertise. Nurse Practitioners (NPs) and other nurses taking on new roles were in need of additional knowledge not offered by traditional routes. Specialty organizations provided education as well as opportunities to discuss the issues facing nurses in these new roles, whereas the ANA did not. The ANA’s dwindling ranks translated into noteworthy financial trouble and resulted in a cyclical problem for the organization. As the ANA ineptly attempted to pursue these specialty groups, it drained the budget, and as the budget drained, the organization was less and less able to respond to the emerging needs of its members.

The ANA attempted to court, and at many times control, not only individual members, but also their specialty groups. To this end, the organization tried several different strategies for reducing the growing divide between its various membership groups, including revisiting the standards of clinical practice, seeking to certify the growing number of nurses with specialty expertise, and administrative and structural reorganization of the ANA itself. The more noteworthy strategy, and the topic of this chapter, was the production of the ANA’s Social Policy Statement (SPS).

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315 Fairman, *Making Room in the Clinic.*
316 Ibid. Arthur Young and Company to ANA Board of Directors, 27 December 1973, Lorraine Freitas Papers, Private Collection, Author. Evaluation of organization’s financial trouble in 1972. The ANA had lost 165K members or 21% of total RN population in practice.
317 There were a series of standards publications between 1975-1978 that addressed some of the emerging specialties. The implementation of these standards was referred to within ANA staff as the “war strategy.” Notes, Staff Meeting, May 1974, Irma Lou Hirsch Papers, Private Collection, Author. The standards publications included the following: American Heart Association Council on Cardiovascular Nursing and American Nurses Association, *Standards of Cardiovascular Nursing Practice* (Kansas City, MO: Authors, 1975); Association of Operating Room Nurses and American Nurses Association,
The ANA SPS was, according to the organization, a response to patients’ changing expectations in terms of the value and contribution nurses made to patient care. The document was outwardly touted as nursing’s answer to the changes occurring in healthcare and public expectations. The quality movement and consumer scrutiny of health care, while largely focused on medical care and specifically physician services, also included nursing care. The internal purpose of the SPS, however, was twofold:

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Standards of Nursing Practice: Operating Room (Kansas City, MO: Authors, 1975); American Nurses’ Association and Emergency Department Nurses’ Association, Standards of Emergency Nursing Practice (Kansas City, MO: Authors, 1975); Orthopedic Nurses’ Association and American Nurses’ Association, Standards of Orthopedic Nursing Practice (Kansas City, MO: Authors, 1975); American Nurses’ Association and American Urological Association, Allied, Standards of Urological Nursing Practice (Kansas City, MO: Authors, 1976); American Nurses’ Association and American Association of Neurosurgical Nurses, Standards of Neurological and Neurosurgical Nursing Practice (Kansas City, MO: Authors, 1976); American Nurses’ Association and Association of Rehabilitation Nurses, Standards of Rehabilitation Nursing Practice (Kansas City, MO: Authors, 1977); American Nurses’ Association, Standards of Pediatric Oncology Nursing Practice (Kansas City, MO: Author, 1978); American Nurses’ Association, Standards for Nursing Services in Camp Settings (Kansas City, MO: Author, 1978); American Nurses’ Association and Association of Operating Room Nurses, Standards of Perioperative Nursing Practice (Kansas City, MO: Authors, 1978).

For details on the organization’s certification programs, see Fairman, Making Room in the Clinic.

The organization underwent three re-organizations over the period of 1965-1984. A growing divide existed between member expectations and ANA’s programs. In a dissertation examining nurses’ perception of the functions of ANA Hopkins found a significant dissonance and/or lack of understanding of the functions of the organization. Calls to focus on the collective bargaining functions of the ANA (or lack there of) were frequent. See Mary Linley Hopkins, “The Perceptions of Registered Nurses of the Purpose and Functions of the American Nurses’ Association,” Ph.D. diss., (Teachers College, Columbia University, 1976).


Patients expected their nurse to be competent, skilled, and knowledgeable about the diseases and associated issues they faced when ill. See chapter 1 for how patient’s expectations manifested. There were numerous professional publications examining the state of nursing in terms of practice, regulation, and education. Two authors in particular are frequently cited. See Jerome P. Lysaught, An Abstract for Action (New York:
solidify the organization’s purpose and clarify the role of specialty practice in
nursing.\textsuperscript{323} So, while the SPS served to publicly address the shift in expectations of
nurses, it also served the ANA’s business interests at the time. The ANA conceived the
policy statement as a consensus tool designed to unify differing interests by offering a
definition of nursing practice and a delineation of the problems relevant to nursing that
the membership could rally behind.\textsuperscript{324}

Unfortunately for the ANA, the SPS was anything but unifying; in fact, it had a
divisive effect. The policy statement’s definition of nursing garnered significant protest
from the emerging specialty organizations.\textsuperscript{325} It also drew commentary from nurse
leaders such as Virginia Henderson who expressed concern about defining nursing too
narrowly.\textsuperscript{326} This and other complaints about the SPS revealed that no matter what type


\textsuperscript{323} See the introduction of the SPS. American Nurses’ Association, \textit{A Social Policy Statement}.

\textsuperscript{324} In June of 1980, the ANA Executive Director Myrtle Aydelotte distributed a paper to the staff entitled \textit{"WE, The ANA, ARE ALL RIGHT."} The paper was reflective of a
general sentiment throughout the organization that outwardly ignored many of the crises while reassuring itself that ANA was not in any trouble.

\textsuperscript{325} The SPS garnered responses from over 70 nurses or nursing specialty organizations.

\textsuperscript{326} Virginia Henderson to Norma Lang, Chairperson, Congress for Nursing Practice, 26 June 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
of explanation of nursing practice was provided, nurses would have diverse sets of opinions on the nature of their practice.

The policy statement also called for a clear delineation of the problems germane to nursing practice, and to that end, a task force was formed and charged with identifying phenomena of interest to nursing. The ANA Taxonomy Task Force, formed just after the release of the SPS, was faced with determining several critical positions for the ANA. One of the task force’s immediate challenges was deciding how to proceed with specialty organizations, as many, like the Association of periOperative Registered Nurses, had started to create their own taxonomy. These taxonomies essentially represented practice patterns and were organized according to what made the most sense for their users. Because these taxonomies were far more responsive to the demands of patient care, they were necessarily more diverse, and this, of course, did not mesh with the uniform perspective on nursing that the ANA hoped to promote.


Before discussing the SPS, it is important to understand the ANA’s level of response to the substantial changes occurring in nursing practice during the mid 1960s. In September 1965, there were several reports made to the board of directors proposing changes to the structure of the organization. The primary issue under consideration was

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328 Initially, the SPS Implementation Task Force was formed, and from that group, the task force on nursing phenomena was formed. The first meeting was held in January of 1982.
329 Report, Study Committee on the Functions of ANA, May 1962, Irma Lou Hirsch Papers, Private Collection, Author; Proposed Plan for Functions and Structure of ANA, Prepared by the Study Committee on the Functions of ANA, 1964, Irma Lou Hirsch Papers, Private Collection, Author; Proposed Plan for Functions and Structure of ANA,
how the organization would encompass the growing number of nurses engaged in ever more diverse clinical roles. The choice, as the board viewed it, was how specific the divisions on practice should be. In 1966, the decision was made to err on the side of broad categories for nursing practice because the organization felt this was the best route to maintain unity within the membership.

In 1968, changes were again initiated during the House of Delegates meeting and the Congress for Nursing Practice was formed. The ANA touted this change as reflecting the central focus of the organization—nursing practice. The organization retained these five divisions: community health, gerontological, maternal-child health, medical-surgical, and psychiatric-mental health. The congress met three times between 1968 and 1970 (a fourth meeting was planned but cancelled for budgetary reasons) and addressed its authority within ANA, as well as two other issues of note—the absence of a "place" within the ANA structure for the clinical nurse specialists and the lack of a definitive statement on the scope and nature of nursing practice. The debate about absence of place for clinical nurse specialists reflected the growing concern that the ANA was not responsive to the needs of nurses. Discussion on where to place the advanced practice nurse was difficult because of the ANA’s tendency to craft its services to meet the needs of staff nurses. The congress, addressing the second issue, argued that creating


a statement on the scope of nursing practice was necessary because of the growing number of new health workers and the extended role of the nurse. Although discussion of these two issues raised awareness of the changes in nursing practice, the congress took no substantial action.\textsuperscript{331}

In the biennium that followed, the congress presented a draft statement on the scope of nursing that both aimed to address the general practice of staff nurses and hinted at the expanded role of NPs.\textsuperscript{332} This draft of the Scope of Nursing Practice, a document intended to outline the general boundaries of nursing practice, achieved its purpose, but in a restrictive fashion for nurses in advanced roles.\textsuperscript{333} However, little debate emerged over this document, and the increasing number of demands placed on the Congress for Nursing Practice overshadowed it.\textsuperscript{334} In response to increasing pressure, the congress' primary concern was to develop a certification mechanism that correlated with the Standards of Nursing Practice.\textsuperscript{335} The congress proposed that certification take three

\textsuperscript{331} This was in part because the congress was busied with the work of establishing its responsibilities within the organization.


\textsuperscript{333} The document limited the diagnostic scope of nurses diagnosing and treating illness by outlining the responsibilities of the nurse in terms of human responses to problems, but stopped short of adding "not the problem itself." It also outlined separating nursing practice into three levels. Scope of Nursing Practice, First Draft, Congress for Nursing Practice, 2 July 1971, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee. Scope of Nursing Practice, Working Paper, Congress for Nursing Practice, 17 April 1972, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.

\textsuperscript{334} Issues surrounding certification and the formation of the National Joint Practice Commission were the primary focus of the congress. Report to the American Nurses' Association House of Delegates, Congress for Nursing Practice, 1970-1972, Irma Lou Hirsch Papers, Private Collection, Author.

\textsuperscript{335} A committee was appointed during the 1970-1972 biennium to create and disseminate standards of nursing practice. There were six standards created and they reflected the
forms: one for technical general practice, one for professional general practice, and one for specialty practice. These certifications did little to represent the range of specialization emerging in nursing; instead, they reflected ANA’s conception of nursing practice at the time.

Additionally, the congress addressed the emergence of new health workers, specifically physician’s assistants and NPs, by creating a new venue for their issues. In August of 1971, the ANA Congress for Nursing Practice met with the American Medical Association’s Committee on Nursing to explore the formation of the National Joint Practice Commission. The commission was formed and immediately charged with identifying and recommending ways both professions could improve patient care. Commission membership comprised members of both organizations who maintained a 50% patient care position.

During the years 1972–1978, the work surrounding the initiatives outlined above became more complex. The Scope of Practice Statement was not enough to sufficiently

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address the changes occurring in practice, and of particular concern to the ANA, the
needs of its membership. Members participating in their constituent state-based
organizations were faced with growing pressure by NPs to change their states’ nurse
practice acts. These acts were unique to each state, and as such varied. ANA had released
a Model Nurse Practice Act in 1954 and a revised version in 1964, and decided the time
was right to once again revise the document.\footnote{Report to the American Nurses’ Association House of Delegates, Congress for
Nursing Practice, 1972-1974, Irma Lou Hirsch Papers, Private Collection, Author.}

The task force of the Congress of Nursing Practice recommended that the
definition of nursing practice be stated in terms broad enough “to permit flexibility in the
use of nursing personnel within the bounds of safety.”\footnote{Ibid., p. 46.}
This proposal reflected the
organization’s growing trepidation that failing to engage with and consider the needs of
advanced practice nurses, primarily NPs, would result in the ANA losing what it
perceived as its long-standing influence over the whole profession.

The Congress for Nursing Practice began implementing the standards developed
between 1974 and 1976 that addressed numerous specialty practice areas, placing them
under the umbrella of quality assurance. Meanwhile, efforts to establish a certification
program for nurses with specialty expertise had changed direction as the ANA was forced
to work with emerging specialty organizations that had initiated their own certification
programs.\footnote{In response to a motion passed by the Federation of Nursing Specialty Organizations,
the ANA began to work cooperatively with the group to identify mechanisms for
certification. This was not something the ANA wanted to do, and it did so with great
hesitation and resentment. In a fabricated memo circulated within the ANA, a staff
member poked fun at the Federation of Nursing Specialty Organizations. Each specialty

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of nursing" at ANA headquarters. The goal of the meeting was to define independent practice, citing its historical relationship with private duty nursing, but also stressing important differences, mainly that independent practitioners, unlike private duty nurses, make their own personnel policies and have 24-hour responsibility for patients.

This meeting, and the persistent, growing call for ANA to meet the needs of this population of nurses, prompted the Congress for Nursing Practice to consider expanding the Divisions on Nursing Practice. This request was directed to the group primarily because their function within the organization was to oversee and coordinate the policies for the ANA with regard to credentialing, standards, and so forth. In 1976, the House of Delegates had asked the congress to consider selecting divisions that represented practice-based specialties such as critical care and emergency, but the congress decided to postpone creation of new divisions and keep the current structure.

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341 Unfortunately, no specific names or definition accompanied the report. It was an interesting and important meeting to note, however, because it demonstrated ANA recognition that the needs of this portion of their membership were not being met.

342 Committee on Interrelationships Report, Section three, Special and Diverse Interests of Member, August 1972, Lorraine Freitas Papers, Private Collection, Author; Committee on Interrelationships Report, Section Three, Relationships Between and Among Units of ANA and Other Organizations of Nurse Practitioners, June 1974, Lorraine Freitas Papers, Private Collection, Author.

Credentialing, standards, definitions of practice, quality assurance, specialization, scope of practice, and generic practice acts were all strategies the organization used not only to address the expanding roles of nurses, but also to respond to the growing public concern over the quality of services provided by physicians and nurses. However, the organization was attention-weary because of the diversity of the strategies it was attempting to implement, and member and executive leadership was beginning to call for a document to pull all these strategies together. Again, the ANA called for a definition of nursing, one that addressed all the changes occurring in nursing practice. Oddly enough, this single, generic definition was supposed to include descriptions of specialized nursing practice.

During the 1978–1980 biennium, the Congress for Nursing Practice, chaired by Norma Lang, appointed the Task Force on the Nature and Scope of Practice—

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344 The ANA had initiated several strategies to account to the public “quality” care. Of note was a task force formed in 1979 that was examining entry into practice. The task force was a result of growing concern over the educational preparation of nurses and a needed informational source for several of the strategies related to legal definitions of practice, standards implementation, etc. The ANA had prepared several papers during the time period addressing what the ANA saw as different types of nurses. Cynthia Cizmek, Coordinator, Nursing Education, Nursing Resources Department to State Nurses Association, Executive Directors, Presidents, Liaison Representatives, 21 December 1979, Lorraine Freitas Papers, Private Collection, Author; Legal Definitions of Nursing Practice, American Nurses’ Association, 7 May 1974, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee; Use of Terms “Professional” and “Technical”, Report to the American Nurses’ Association, Board of Directors, 12 February 1976, Irma Lou Hirsch Papers, unprocessed, Private Collection, Author; ANA’s Stand on Entry Into Practice, American Nurses’ Association, December 1978, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee; Perspectives on Entry into Nursing Practice, American Nurses’ Association, 1978, Lorraine Freitas Papers, Private Collection, Author. Resolution #56, Identification and Titling of Establishment of Two Categories of Nursing Practice, 1978, Lorraine Freitas Papers, Private Collection, Author.

345 Norma Lang, personal communication, March 21, 2008.
Characteristics of Specialization in Nursing and charged the group with developing such a definition. Lang agreed to oversee this task force as part of her term as chair of the Congress for Nursing Practice, but only under the condition that the document be created, reviewed, and distributed within a year. Lang stressed the importance of keeping the time limit tight because she felt that if the process were any longer, nurses would never come to a consensus. Moreover, there was a sense of urgency to complete the task by the 1982 convention because there was a pending resolution to consider reorganizing the ANA’s structure that would include a division for NPs.

The charge of the task force was first and foremost to develop a definition of the nature and scope of nursing practice that included delineation of the characteristics of specialization. These “characteristics” were things such as determining the educational preparation required for entrance into specialty practice and identifying specific areas for certification. Once these criteria were established, it could then be used to organize the

347 Norma Lang, personal communication, March 21, 2008.
348 Minutes, Congress for Nursing Practice, American Nurses Association, 7-8 November 1978, Irma Lou Hirsch Papers, Private Collection, Author.
349 Ibid.
350 The ANA had evaluated various aspects of the credentialing issue. It was under an acute sense of pressure as the American Hospital Association and other groups like the Joint Commission on the Accreditation of Hospitals were concerned over the regulation and management of emerging specialty practice areas; areas like critical care, obstetrics, and neurology. Summary of Responses From Hospital Associations on Licensure and Mandatory Continuing Education, Fall 1977, Irma Lou Hirsch Papers, unprocessed, Private Collection, Author; Barbara Bloom, Secretary, Council on Manpower and Education, American Hospital Association to Special Committee on Continued
ANA’s clinical units and, with application of the definition, support changes to licensure statutes.

The task force was composed of ANA members who had "[the] ability to think, articulate orally and in writing, listen, [and] compromise, [as well as] previous experience with statement development, and an in-depth understanding of the practice of nursing." The first meeting, held on January 9, 1980, was attended by six ANA members and one linguistic consultant. The task force comprised two clinicians (NPs), Jean Steel and Nina Argondizzo, and four faculty, Norma Lang, Kathryn Barnard, Hildegard Peplau, and Maria Phaneuf. Additionally, Ruth Lewis and Kathryn Goldring were ANA staff.
who assisted the task force. Each was asked to prepare a paper prior to the first meeting that addressed definitions of nursing and issues concerning specialization and credentialing.

The task force, under the facilitation of Lang, produced a draft document of the SPS rather quickly. However, outside the group, other structural divisions in the ANA were not pleased with the definition. The Division on Community Health Nursing Practice raised concerns about the lack of clinician representation, specifically staff nurses, both in terms of task force membership and in the document in general. Moreover, the division felt that the plan to review the document was limited—one draft and then a final version—without review by ANA constituents. Despite protest in late April 1980, the task force released a draft to the structural units, and then in June, during the convention, to members of the ANA. The responses began to come in during late May to both ANA staff member Ruth Lewis and task force chair Norma Lang. The majority of the comments from within the ANA generally focused on the language used in the document. Comments like “too wordy,” “too long,” “doesn’t read well,” “lots of

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354 Kathryn Goldring oversaw the publishing of the SPS for the ANA. Ruth Lewis participated during preparation of the draft and final version of the SPS. She quit her job at the ANA four months after the SPS was released. She said she left the ANA because she was disillusioned with the lack of professional behavior in the organization. Ruth Lewis to Norma Lang, 22 May 1981, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.

355 Executive Committee Division on Community Health Nursing Practice to Norma Lang, Chairperson, Congress for Nursing Practice, 22 February 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.

356 American Nurses’ Association, Draft Report, Characteristics of Specialization.
rhetoric,” and “too general” were common. In addition, in light of the language choices in the statement, many wondered who the intended audience was. Was it nurses? Patients? Both? The questions were legitimate. By the committee’s own account, stated in the first section of the April draft, the intent of the SPS was to clarify nursing’s commitment to patients. Yet the document was much more reflective of the ANA’s current ills such as declining membership brought about by specialization, and little consideration was given to the patients as a potential audience. By the task force’s own account the SPS was intended to “bring coherence to the policies and programs of the association.”

The draft attempted to deal with the issue of specialization in each of its three sections. In the first section, The Social Context of Nursing, the task force outlined content on the interaction between a society and a profession, identified some of the current trends in health care spending, summarized nursing’s claim to a unique focus on health, and outlined what now was a long-standing call for collaboration with “other health professions,” a generic reference to physicians. Of the five subsections in the SPS, the first four reflected the professional centricities of the organization, while the last

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357 Catherine Dodd, Alternate Commissioner Region 12, California Nurses Association (CNA) to Norma Lang, Chairperson Congress for Nursing Practice, 8 July 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee; Francis Waddle, Coordinator, Ethical and Legal Aspects of Nursing Practice to Ruth Lewis, Director, Nursing Practice Department, 12 May 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee; Margaret Ann Quan, Secretary, American Nurses’ Association to Norma Lang, June 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
358 Clinton DeWitt to Norma Lang, 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
359 American Nurses’ Association, Draft Report, Characteristics of Specialization.
360 Ibid., quote on p. 1.
361 Ibid.
one addressed the need for exercising authority over nursing practice, the position ANA felt was its role.

The Social Context of Nursing section comprised four fairly clear subsections, with the last section, "Authority for Nursing Practice," addressing the five functions of the ANA. If the task force had stopped at the first three functions—establish a code of ethics and standards of clinical practice, establish minimal education standards for entry into practice, and certify clinicians in specialized area—the remaining portion of the SPS could have gone on to simply outline how these elements supported nursing’s social contract to the public.

However, there were two remaining functions identified. The first, "fostering development of nursing theory, derived from nursing research into those conditions that are the focus of practice, so as to explain and guide nursing actions," was a rather odd addition to a document that was largely tasked with representing how nursing served the interests of the public. Such an addition was especially problematic given that the task force failed to include a description of what nursing does for the public, how that is accomplished through educational preparation, and how, through the general regulations proposed earlier in the document, the ANA ensures the public’s safety through both ethical and clinical standards. Task force chair Norma Lang and member Jean Steel recall that this section was something Peplau had wanted in the document. Peplau’s insistence that theory be included in the discussion was reflective of her own

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362 Ibid., p. 5.
363 Ibid.
364 Jean Steel, personal communication, March 17, 2008; Norma Lang, personal communication, March 21, 2008.
understanding of specialization; an understanding that was based on advanced education in a traditional university setting. This addition supported by the task force later became problematic as the statement made its way to more and more nurses.

The task force defined the final function as “other development work directed toward making more specific nursing’s accountability to society.” The vagueness of this last statement left room for interpretation, and in doing so, delineated no clear direction for the organization with regard to its many programs. Apparently, this nondescript approach was intentional; Lang, the chair of the task force, cautioned the group to manage the specificity expressed in the document by being as nondescript as possible in order to avoid further marginalization of the specialty organizations. The key here is that “other development work” was to be determined by the ANA, not any other group.

Despite hitting a measurable generic approach that was intended to satisfy internal expectations, the draft did not contain elements that many individuals within the organization anticipated. Connie Holleran, Director of ANA’s Government Relations, in a memo forwarded to the task force, expressed her concern over the focus on providers rather than on outlining what nurses do for patients in the form of increased access to

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365 Peplau was a proponent of advanced education for nurses who were specialized that included a strong foundation in theory.
367 Notes, Norma Lang SPS Draft Communication, estimated date February 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee. The generalist approach garnered comments from Ida Orlando Pelletier who stated “overall, too much is stated too generally in the draft…” Ida Orlando Pelletier to Norma Lang, 23 May 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
368 Ibid.
health care, affordability, and individualized services. She was also concerned over the lack of recognition of the specialties and how these expert nurses were being equated to "special interest groups," something she thought was "problematic." For Holleran, whose work responsibilities extended to lobbying and other forms of influence on policy matters, identifying what services were available and being provided by particular types of nurses was paramount. Designating the specialties as "interest groups" had the potential to lessen her ability to lobby effectively, primarily because the ANA was a political interest group itself. The designation of "interest group" split the membership into even smaller sections, thus lessening the lobbying power, part of Holleran's job at the ANA. Compounding this difficulty, she commented about her "[constant] embarrassment by the lack of specific information in this area." Holleran essentially had no data to illustrate the extent of specialization or what it accomplished, and therefore found it difficult to answer legislative inquiries or develop coherent political strategies.

Unfortunately, the type of political challenges the ANA was concerned with were largely internal ones. In a memo, Francis Waddle, coordinator of the Ethical and Legal Aspects of Nursing Practice Council, raised objections to portions of the statement that

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369 Connie Holleran, Director, Government Relations Division to Ruth Lewis, Director, Nursing Practice Department, 14 May 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
370 Holleran is referring to page 12 of the Draft SPS.
371 Ibid.
372 Ibid.
equated specialization with advanced education above the associate and diploma level.\textsuperscript{373} Waddle was concerned because many nurses' self-selected specialization was through informal routes such as job affiliation rather than through formal education.\textsuperscript{374} The issue was raised because many of the core constituency of the ANA were staff nurses, some of whom were in the very jobs Waddle described, and the statement might alienate them. The ANA could not risk upsetting this group, for even though the SPS was about specialization, the bread and butter of their membership—the financial solvency of the organization—was tied to the staff nurse.\textsuperscript{375}

No changes were made to the draft version of the SPS that was presented at the ANA convention held June 8-13, 1980 in Houston, Texas. Chairperson Lang presented this first and only draft of the SPS to the House of Delegates.\textsuperscript{376} After the presentation, Elaine Beletz of New York drew attention to the ANA’s Model Nurse Practice Act and suggested that ANA stop publication and dissemination of the SPS.\textsuperscript{377} Beletz believed that the definition of practice used in the SPS unnecessarily hindered the pursuit of legislation that would be free of unwarranted supervision by physicians. The definition in the SPS draft limited nurses' treatment of patients to “human responses to actual or

\textsuperscript{373} Francis Waddle, Coordinator, Ethical and Legal Aspects of Nursing Practice to Ruth Lewis, Director, Nursing Practice Department, 12 May 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.

\textsuperscript{374} Ibid.

\textsuperscript{375} Fairman discusses, in her book on the nurse practitioner movement, the financial troubles of ANA in the early 1970s. These troubles plagued the organization for some time to come, and particularly made the ANA sensitive to moves that might reduce its membership further. See Fairman, \textit{Making Room In the Clinic}.


potential health problems,” rather than diseases. This was a major issue for many of the NPs who were pursuing changes in their state nurse practice act that would allow them to diagnose, and logically, they looked to their professional organization for assistance and support. Chairperson Lang assured Beletz and other nurses concerned about practice legislation that the congress would consider these concerns, but offered no specific changes to the SPS.

At the convention, Lang had requested that conference attendees submit written comments on the SPS, and these came in during the weeks and months to follow. Many of the nurses cited dissatisfaction with the time crunch to provide feedback to the task force; all comments were to be received by the end of July, just six weeks after the SPS initial introduction, if they were to be given any consideration before production of the final version of the document. Just as the ANA staff had commented on the language during the internal review, so too did the general membership. Jane Ulsafer of Rush Presbyterian Medical Center urged “clear writing and direct wording.” The Professional Advisory Committee of the Association of Operating Room Nurses objected to the language choices, which they described as confusing, and stressed the need to

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379 Margaret Hicks, President, National Association of Pediatric Nurse Associates and Practitioners (NAPNAP) and Barbra Dunn, Executive Director, NAPNAP to Norma Lang, Chairperson, Task Force on the Nature and Scope of Nursing Practice, 9 July 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
380 Jane Ulsafer-Van Lanen, Associate Chairperson, Department of Psychiatric Nursing, Rush-Presbyterian Medical Center to Norma Lang, 17 June 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
specify various terms. Shirley Bird, another delegate, also emphasized the need to clarify terminology, especially in the document’s third section, which addressed specialization.

The third section of the draft, Specialization in Nursing Practice, discussed the role and functions of “specialists in nursing practice.” Because this designation was given only to nurses who had graduate education, the section seemed to directly challenge staff nurses in specialized roles and was interpreted as such. Many of the attendees voiced their concern that delineating the definition of specialist and anchoring it to a degree would alienate staff nurses in critical care and similar areas. Kathryn Hall from the University of Maryland Hospital and chairperson of the Clinical Nurse Specialists Group, questioned how the task force was going to “differentiate nurses who are specialized but do not hold master’s degrees, from those who do [hold master’s degrees].” Catherine Dodd, Alternate Commissioner, Region 12, California Nurses Association (CNA), concurred with Hall. Dodd was concerned with how, for example, intensive care nurses would fit into this outline of specialized practice, as “they don’t

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381 Professional Advisory Committee, Association of Operating Room Nurses, Inc. to Norma Lang, 18 July 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
382 Shirley Bird, College of Nursing, University of Tennessee to Norma Lang, 27 June 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
384 Kathryn Hall, Chairperson, Clinical Specialist Group, University of Maryland Hospital to Norma Lang, Chairperson, Congress for Nursing Practice, 10 July 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
need [an] MSN. Rosemary Dale, a nurse administrator in Vermont, circulated the SPS to her assistant head nurses, head nurses, and clinical coordinators (managers), all of whom responded by pointing out that specialization was not necessarily tied to advanced education. This debate was the result of task force member Hildegard Paplau’s views on specialization, and in particular, her belief that an advanced education should provide the only means for nurses to specialize.

However reflective these comments were of the content of the SPS, they represented concerns about the document from nurses who were not NPs, the target audience of the SPS. While the ANA was certainly troubled by the general effects of specialization, they saw the role of NP and organizations that represented these nurses as politically powerful and therefore more threatening. The NP was a central focus of the ANA’s definition of specialization, which that was tied to a new, politically powerful constituency that the ANA was quickly losing, if it had not already been lost.

Unfortunately for the ANA, NPs also responded unfavorably to the draft SPS.

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385 Catherine Dodd, Alternate Commissioner Region 12, CNA to Norma Lang, Chairperson Congress for Nursing Practice, 8 July 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
386 Rosemary Dale, Administrator Nursing Services, Medical Center Hospital of Vermont to Hildegard Peplau, 27 June 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
387 Jean Steel, a task force member and NP, remembers how she went round and round with Peplau on the issue of specialization. Steel recalls that Peplau did not agree with the work she was doing, positing that Steel was practicing medicine. Part of Steel’s position included independent practice for nurses that included needed changes to nurse practice acts. Peplau’s position was not necessarily as Steel portrays, she supported specialization and general advancement, she simply did not see the need to expand practice acts. Yet, despite the disagreement between the two, Peplau’s articulation of specialization moved forward. Steel and Lang both commented that they were working with “elder statesmen” of the nursing profession (Peplau and Maria Phanuef), and so the two conceded. Jean Steel, personal communication, March 17, 2008.
The second section, The Nature and Scope of Nursing Practice, received the most criticism from a variety of nurses involved with the NP movement. Mary Crane, a family NP who had attended the forum in Houston, reiterated her criticisms in a memo to task force chair Norma Lang. She objected to the way in which section 2 equated the acquisition of the skill of physical assessment with achievement of the role of NP. So did the members of the CNA, Catherine Dodd, Marilyn Chow and Jo Anne Powell; Margaret Hicks and Barbara Dunn of the National Association of Pediatric Nurse Associates and Practitioners (NAPNAP); and Ernestine Kotthoff, chairperson, Council of Primary Health Care Nurse Practitioners. All thought that the skills of assessment alone did not make a NP. The role represented a compilation of skills, knowledge, and a willingness to cooperate and negotiate with physicians about how specific responsibilities were shared.

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388 Mary Crane, Family Nurse Practitioner to Norma Lang, 25 June 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
389 A clarification on this citation is needed. Dodd wrote in order to represent the CNA and her region’s membership. So in her letter, she addressed both the general staff nurse concerns and the concerns of the nurses who were NPs. Catherine Dodd, Alternate Commissioner Region 12, CNA to Norma Lang, Chairperson Congress for Nursing Practice, 8 July 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
390 Jo Ann Powell to Marilyn Chow, 24 June 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee. Comments on draft SPS.
391 Margaret Hicks, President, National Association of Pediatric Nurse Associates and Practitioners (NAPNAP) and Barbra Dunn, Executive Director, NAPNAP to Norma Lang, Chairperson, Task Force on the Nature and Scope of Nursing Practice, 9 July 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
392 Ernestine Kotthoff, Chairperson, Council of Primary Health Care Practitioners, Denver Colorado to Norma Lang, 1 July 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
This went along with the task force’s co-opting of the term “nurse practitioner” and defining it as the title for all professional nurses. Professional nurses were defined in the SPS draft as any nurse possessing at least a baccalaureate degree. Kartthoff urged the task force not to say that all professional nurses were NPs. However, Margaret Hicks and Barbara Dunn of NAPNAP voiced the strongest objection, arguing that “the term nurse practitioner is not now and will not be ‘recognized as an appropriate designation for all professional nurses.’”

NAPNAP was displeased with the ANA, the task force, and the document. In their letter to Lang dated July 9, 1980, the group questioned the assumption that the “ANA alone should and does speak for all of nursing.” The group stressed that the SPS document was not one born out of “political feasibility.” NAPNAP was referring to the limited number of individuals able to contribute to the document, the short time span allotted for submitting feedback, and the task force’s failure to invite other groups such as NAPNAP to contribute. They went further, stating that the ANA’s lack of cooperation and the disregard to the “customary [need] to gain support by involving those groups in

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393 This was a throw back to pre-1965 when any nurse who practiced was labeled as such. This was a poor decision made by the task force because the context of when, where, and by whom the term was used had changed. It had a different, commonly understood connection to this new type of nurse. American Nurses’ Association, Draft Report, Characteristics of Specialization, p. 8.
394 Ernestine Kotthoff, Chairperson, Council of Primary Health Care Practitioners, Denver Colorado to Norma Lang, 1 July 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
395 Margaret Hicks, President, National Association of Pediatric Nurse Associates and Practitioners (NAPNAP) and Barbra Dunn, Executive Director, NAPNAP to Norma Lang, Chairperson, Task Force on the Nature and Scope of Nursing Practice, 9 July 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
396 Ibid.
397 Ibid.
initial development of the policy … is apparent in the draft.”\textsuperscript{398} The group concluded with the following statement: “NAPNAP believes others who would be affected by and expected to implement this policy should have been involved.”\textsuperscript{399}

Soon after the Houston meeting, Jean Steel, a task force member and NP, had already started to rewrite, in its entirety, the section on the NP. Steel sent it to Lang in early July, along with her comments on the section. She stressed that the “[nurse practitioner] movement was accomplished by expanding [the nurse practitioner’s] assessment skills and then implementing, by the use of guidelines, … care. The scope of [the nurse practitioner is] more appropriately defined by patient care responsibilities.”\textsuperscript{400}

The task force received comments on the draft that largely centered around two issues. The first issue was that the authors of the SPS equated specialization with the NP movement. The NP role required unique skills and knowledge, but that role alone did not make up the totality of the specialization trend in health care, which extended to many care areas necessitating refined and focused nursing care.\textsuperscript{401} The second category of responses focused on the ANA’s assertion that the acquisition of the skill of physical assessment defined the NP role. However, for the ANA’s purposes, differentiation between the staff nurse role and the NP role had to be based on something. Assessment was a logical choice because the changes occurring in practice demanded that nurses

\textsuperscript{398} Ibid.
\textsuperscript{399} Ibid. NAPNAP and the ANA had, by 1980, what could be considered a long-standing adversarial relationship, particularly over the issue of who spoke for nursing. For more on this, see Fairman, \textit{Making Room in the Clinic}.
\textsuperscript{400} Jean Steel, Primary Care Graduate Training Program, Boston City Hospital to Norma Lang, 8 July 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
\textsuperscript{401} For example, medical-surgical units required a different set of skills and knowledge than critical care, but not necessarily the skills and knowledge of an NP.
execute the skill and because the ANA was equating acquisition of the skill with specialization.\textsuperscript{402} It is unclear whether this differentiation represented the ANA’s fundamental lack of understanding of the changes occurring in the practice of the generalist’s nurse or whether such a definition was merely an expedient, although misdirected, way to define the NP’s role. Despite the possible motives, the task force conveyed a lack of understanding of practice specialization in general, and the role of NPs in particular.

\textbf{Revision of the SPS}

The task force took many of the comments into consideration as they proceeded to revise the document in the remaining five months of 1980.\textsuperscript{403} The end result was a 32-page, single-spaced booklet outlining nursing’s relationship with the public. The introduction, less one paragraph, was new. The changes to this section were reasonable, as the draft explained the process of generating the statement and outlined the statement’s purpose. Interestingly, the introduction contained a paragraph that stated the following: “Attempts to ... delimit nursing more clearly ... would have been potentially harmful.”\textsuperscript{404} This insertion was likely included in response to the critique the task force received over the definition of nursing practice. Moreover, the task force recognized the care needed in

\begin{footnotes}
\item \textsuperscript{402} Specialization of nursing work by skill type and level was similar to what was occurring in medicine. See Rosemary Stevens, \textit{American Medicine and the Public Interest}, (San Francisco: University of California Press, 1998).
\item \textsuperscript{403} Unfortunately, there was little material to review that can provide insight into why certain changes were made to the document and by whom. Only the draft and the final version of the document were available, and comparing the two merely illustrates what items were removed, added, or changed. According to Lang, Steel, and Kathryn Goldring, the majority of the document was generated by Peplau and Phanuef. The revision of section two, not withstanding the definition and description of nursing practice was Lang and Steel. Nina Argondizzo and Glen Webster played minimal roles. \\
\item \textsuperscript{404} American Nurses’ Association \textit{A Social Policy Statement}, quote on p. 2.
\end{footnotes}
defining nursing practice, for if they stated the scope of practice for some nurses such as NPs, the ANA could be seen as directly challenging medical practice. Essentially, the SPS could potentially become a rallying point for physicians and the American Medical Association (AMA) by deliberately and openly laying claim to clinical reasoning and diagnosis. So, the task force sought to strike a general tone with its descriptions, rather than specifically identify each and every aspect of nursing practice.

The document’s first section, entitled The Social Context of Nursing, remained virtually the same. The task force added to the second section, The Nature and Scope of Nursing Practice, extensive new material detailing the nursing process, complete with diagrams and illustrations detailing the interaction between nursing theory, nursing process, and standards of practice. It was here that the task force made some of the more controversial changes. Even though the group had received feedback about the definition of nursing practice, the definition was virtually unchanged. However, the group added a paragraph that aimed to explain the definition, a section that would come to be known as paragraph one, page 10. The explanation stated clearly and overtly that nurses did not treat diseases. So, despite intentions not to unduly limit nursing practice, the ANA

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405 Throughout the material reviewed on the SPS, there was always a certain amount of care taken to avoid stating that nurses diagnose and treat disease. Part of this was Peplau’s insistence on avoiding unnecessary changes to nurse practice acts, but there was more to it than avoiding the appearance of sanctioning these changes. There was resistance within the ANA to any direct challenge to medicine. We can see this in the SPS, as well as some of the earlier papers on nurses’ scope of practice, where the ANA opted to describe much of nursing’s advancement with cloudy, careful language. The language in the SPS was such that if challenged, it provided the ANA with deniability.

406 There were some slight revisions that moved sections around, but otherwise it remained the same.

407 The task force removed the three qualifiers that were part of the draft definition.
declared that nursing practice did not include the treatment of disease, something NPs
performed on a daily basis.

In the third section, *Specialization in Nursing Practice*, the task force removed the
term NP, opting instead to label all nurses with advanced skills and knowledge as
specialists. They retained the ideas surrounding the need for specialists in nursing to have
advanced education, either a master’s or doctorate, but conceded the point that nurses
with less education also specialized. Additionally, the section on certification was
clarified, and identified the need for both types of specialists to seek out ANA
certification.

**Release and Dissemination of the SPS, 1981–1982**

The Congress of Nursing Practice unanimously approved the SPS, and in January
of 1981 the SPS was released to the ANA’s constituents. Of all the changes, the item that
would prove to be most troubling for the ANA was, once again, the definition of nursing
and accompanying descriptions. The SPS provided a definition of nursing stating that
“nursing is the diagnosis and treatment of human responses to actual or potential health
problems.”408 The document went on to say that “nursing addresses itself to a wide range
of health-related responses observed in sick and well persons. Those responses can be
reactions to an actual problem, such as a disease, or they can anticipate a potential health
problem. Nurses diagnose and treat these responses—not the health problems

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408 This definition was credited to the New York State Nurses’ Association. The language
was part of the Nurse Practice Act of New York passed in 1972. American Nurses’
themselves."\textsuperscript{409} It was the last sentence that garnered the most criticism of the ANA from individual NPs and organizations representing NPs.

Letters of protest poured in to the ANA from all over the country. Kay Ortman, writing in on behalf of the Oregon Nurse Practitioner Group, and Mickey Knutson, President, National Organization of Nurse Practitioner Faculties, both leaders in the nursing world, charged the ANA with being unsupportive of NPs.\textsuperscript{411} Knutson went so far as to accuse the ANA of limiting the practice of nursing and harming the practice of NPs by failing to legitimize their scope. She was particularly upset about the lack of acknowledgement of nurses' ability to "diagnosis and [treat] ... disease."\textsuperscript{412} Knutson went on to say that the SPS's "omission of the curative practices within nursing is evident."\textsuperscript{413} Virginia Henderson also added her comments at the ANA's Council on

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\textsuperscript{409} A health related response is generally a symptom of disease.
\textsuperscript{410} Both Steel and Lang commented that the definition was not to the liking of Virginia Henderson. Henderson, who had articulated her own definition of nursing, felt that the definition offered by the SPS limited nursing practice and added to the confusion about the role and function of the nurse. Unfortunately, her objections and comments on the SPS are largely limited to her verbal responses about the draft (not the final) during each of the three open sessions held at the ANA's 1980 convention. Tapes of these sessions are in the possession of Jean Steel and plans are currently underway to transcribe the material that, once completed, will no doubt add a significant dimension to this discussion. For Henderson's definition of nursing, see Virginia Henderson, \textit{Basic Principles of Nursing Care}, (Geneva, Switzerland: International Council of Nursing, 1972).
\textsuperscript{411} Kay Ortman, Oregon Nurse Practitioner Group to Norma Lang, March 1981, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee; Mickey Knutson, President National Organization of Nurse Practitioner Faculties to Norma Lang, 5 April 1981, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
\textsuperscript{412} Mickey Knutson, President National Organization of Nurse Practitioner Faculties to Norma Lang, 7 November 1981, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
\textsuperscript{413} Ibid.
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Nurse Practitioners meeting in San Diego: “Diagnose and treat. I don’t know why we don’t just come out and say it.”\textsuperscript{414}

Ruth Benson, an NP from Fairbanks, Alaska, wrote the following in a memo to task force chair Lang: “I love all of the gobble-le-gook [\textit{sic}], but what in tarnation does it mean?”\textsuperscript{415} She concluded with the following statement: “We counsel clients to buy iron pills and eat more vegetables, … we advise 20 minutes of exercise, … we instruct soaks and elastic bandage wraps, when we prescribe limited caloric diets, bulk formers, and stool softeners, nasal decongestants, and increased fluid intakes, many times we are assisting clients in their treatment of health PROBLEMS—not ‘human reactions’ to those problems!”\textsuperscript{416}

The gobbledygook Benson was referring to was the language used by the task force to describe what it is that nurses do or act upon on behalf of the patient. Here is where the group authoring the SPS chose not to take the advice given in responses to the draft. Instead of cleaning up the jargon-laden language, they added to it. For example, “human responses to actual or potential health problems” was further defined as “any observable manifestation, need, condition, concern, event, dilemma, difficulty, occurrence, or fact that can be described … and is within the target area of nursing

\textsuperscript{414} Henderson was a well-known leader in the nursing community. She had written her own definition of nursing. She communicated this to Jean Steel, a member of the SPS task force. Steel communicated this to Lang in an informal note attached to a memo detailing the first meeting for the implementation of the SPS. Note, Jean Steel to Norma Lang, 29 January 1981, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.

\textsuperscript{415} Ruth Benson to Norma Lang, 4 September 1981, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.

\textsuperscript{416} Ibid., the quote within her statement was taken from the SPS.
practice. The problem Benson had with the wording of the SPS was that it simply did not capture the work of nurses. The result was a final version of the SPS that managed to include even more confusing language than the draft. Many nurses, including Signe S. Cooper, once again urged Lang to condense the final document and remove the obtuse wording. Cooper worried that the language would be a barrier to any nurse who might use the document as the basis for policy changes. Moreover, the length of the SPS, a total of thirty single spaced pages, was too long to be useful for public consumption.

The vague language was intentional on the part of the ANA and the SPS task force. The ANA, like the AMA, was struggling to keep the profession together. The AMA was dealing with a growing number of physicians engaged in specialized rather than general practice. The AMA worried over the decline in interest in primary care and the influx of other providers such as NPs into that area of practice. The AMA made several attempts to deter this expansion of nurses into primary care, but were unsuccessful.

418 Cooper was one of a handful of nurses who wrote in voicing her support of the SPS. Yet, despite the support, she urged a revision that cleaned up the language. Signe S. Cooper to Norma Lang, 28 November 1981, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee; Joan Mahaffey, Regional Director, California Nurses Association to Norma Lang, 26 June 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee; New York State Nurses Association Council on Nursing Practice to Nina Argondizzo, Member ANA Task Force on the Nature and Scope and Characteristics of Specialization in Nursing, 11 July 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee; Hector Hugo Gonzalez, Chairperson, Department of Nursing, San Antonio College to Norma Lang, 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
419 See FN 442.
420 Fairman, *Making Room in the Clinic*. 
The ANA on the other hand, faced similar challenges and changes in its membership. As the NP movement continued to grow and nursing specialty organizations cut further and further into the ANA’s financial resources in the form of lost membership and related profits, the ANA made numerous attempts to maintain some semblance of relevance to all nurses.\(^{421}\) It was critically important to the ANA to keep hold of some appearance of unity and to make a concerted effort at diluting the effect of specialization so as not to alienate portions of its membership, specifically the generalist nurse.

The ANA leadership expected the task force to articulate that stance. In light of the charge to the task force, Lang, the task force chair, felt it was necessary to strike a careful balance between overstating the role of some nurses and understating the role of others.\(^{422}\) Moreover, Lang knew that this statement, no matter what it contained, could not satisfy everyone. It was a careful document, aimed at appeasing numerous groups of nurses experiencing changes in their practice.

However, the document seemed to create more dissention and division. The National Intravenous Therapy Association sent the SPS task force a letter describing its members’ concerns with the document.\(^{423}\) Eli Studebaker, writing on behalf of their board of directors, noted that they “did not accept the [final] draft of the document.”\(^{424}\) ANA had maintained that the purpose of the SPS was to clarify for itself the issue of

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\(^{421}\) The development of standards, certification, and now the SPS were all part of the strategies employed by the ANA to limit the splits, but also control them.

\(^{422}\) Norma Lang, personal communication, March 21, 2008.

\(^{423}\) Eli Studebaker, National Intravenous Therapy Association, Inc. to Norma Lang, 13 September 1981, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.

\(^{424}\) Many of the nurses writing in referred to the initial publication of the final documents; this was largely because many had not seen the draft.
specialization and its effect on nursing practice. Studebaker questioned the ANA motive, asking the following: "If the intent was to address clinical specialties why were no specialty organizations included?" Studebaker followed this fair, albeit rhetorical, question by citing his objection to the ANA "taking upon itself to speak on behalf of the entire nursing profession."

In fall of 1981, just nine short months after its release, the congress was forced to reconsider its definition and descriptions of nursing practice, particularly the line "nurses diagnose and treat these responses—not the health problems themselves." The Congress for Nursing Practice decided to delete the sentence from the SPS, but not without some hesitation. Apprehension about the ANA's ability to both "achieve professional consensus" around the SPS and raise "awareness, understanding, and acceptance of the SPS on the part of NPs" was at issue. Their thinking was that if the ANA was to "control nursing practice in the workplace, [they] needed to define what the ANA is organizing practicing nurses to practice."

The position the ANA took on the purpose and goals of the SPS was too little too late. Many of the NP organizations had established their own certifications, scope, and program accreditation standards. Essentially, these organizations had defined how nurses were practicing, largely because their membership was made up of practicing nurses. As shown earlier, the ANA and this statement, in a very real sense, simply reaffirmed what

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425 Ibid.
426 Ibid.
429 Ibid.
430 Ibid.
the ANA thought about the work of nurses rather than reflecting the actual work. It was an information practice designed by the ANA, for the ANA.

Implementation of the SPS, 1982–1984

The Task Force on Implementation of the SPS was formed in early 1982 and charged with the continued dissemination and enforcement of the ANA’s new policy. The implementation plan was multifaceted, directed at many of the ANA’s constituency, and “centered around the need for the profession to establish territorial prerogatives.” Again, this reflected the ANA’s need to play a part in these changes in practice, to have some relevance in light of the changes or face further financial and membership losses. The Congress for Nursing Practice believed that, in order to set up these territories, the congress and other parts of the ANA needed to institute control over nursing practice. This management was redefined by the group as “control of quality assurance of practice, state licensure, certification, and standards.” The ANA viewed their five-year master plan for implementing all the policies in the SPS as the key to this success.

The master plan included revision and implementation of existing practice standards, establishment of a credentialing program, and reissuing of the generic model

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431 This task force was under the Congress for Nursing Practice.
433 These were not new initiatives for the ANA.
434 In a letter written by Kathryn Barnard to Ruth Lewis, the SPS task force member remarked “The thought has occurred to me that the statement might be so popular and well accepted that we [h]ardly need an organized system of dissemination.” Kathryn Barnard to Ruth Lewis, 1982, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee. The plan was part of the Revised, Worksheet for Defining and Implementing Policies on Professional Practice, Congress for Nursing Practice, 1980, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
for state licensure.\textsuperscript{435} The quality assurance aspect of the plan was a bit more complex, as it incorporated not only initial standards revisions, but also included the Sutherland Project.\textsuperscript{436} This project was an independent learning module on quality improvement developed in 1981–1982 by the ANA in conjunction with Sutherland Associates, Inc. The module provided a program for evaluating care in three areas: long-term care, acute care, and community health. Basically, the program was developed to provide nursing services in these three areas with the tools to implement ANA standards and evaluate the nursing care provided against those standards.

As part of this implementation plan, the ANA created a taxonomy for nursing practice. In cooperation with SPS Task Force member Kathryn Barnard and Ada Sue Hinshaw, chair of ANA's Commission on Nursing Research, Lang had initiated the formation of a task force to identify phenomena of interest to nursing.\textsuperscript{437} This task force was to build on the ten categories of “human responses” identified in the SPS.\textsuperscript{438} The organization felt that this taxonomy was “essential if nurses [were] to defend what they

\textsuperscript{435} These were not new initiatives, but now under the SPS the ANA had a document to point to that supported their actions.
\textsuperscript{436} Minutes, Congress for Nursing Practice, American Nurses Association, 13-16 February 1982, Irma Lou Hirsch Papers, Private Collection, Author.
\textsuperscript{437} The task force was formed 6 months after the release of the SPS. The request to ANA was initiated by Norma Lang and Ada Sue Hinshaw on Aug. 12, 1981, approval from ANA executive director was granted on August 24, 1981. The first meeting of the task force was scheduled for December 17\textsuperscript{th}, 1981, but was delayed until January 5\textsuperscript{th} & 6\textsuperscript{th}, 1982. Irma Lou Hirsch Papers, Private Collection, Author.
\textsuperscript{438} Minutes, Congress for Nursing Practice, American Nurses Association, 13-16 February 1982, Irma Lou Hirsch Papers, Private Collection, Author.
do, what the expected outcomes [were], and how they [were] to be held accountable for those (original emphasis)."

In the six months leading up to the taxonomy committee’s first meeting, discussion of the approach to development focused on the ANA creating its own taxonomy. Exuberance and excitement over the apparent call to action in the SPS led many of the ANA leadership, particularly Lang and Ada Sue Hinshaw, to believe this was a major undertaking for the organization. Lang, on behalf of the task force, had begun polling ANA practice divisions for submissions of NDs. However, the ANA’s support of the taxonomy development was in spirit only, as there were limited funds allocated to the task force for its work. This tempered approach led the task force to reconsider its approach to developing the taxonomy.

During the first meeting of the Taxonomy Task Force in January 1982, other organizations expressed concern over the apparent competition the ANA posed to their own taxonomies. Lang, wanting to avoid any appearance of the ANA taking over the area of taxonomy development, proposed to change the name of the task force to the steering committee. This was in part because she knew there was no power behind the ANA’s support of this initiative, and if it was to be successfully launched, it would only

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439 Minutes, American Nurses’ Association, Board of Directors, 16-17, 20 September 1980, Box 499 F6, ANA Board of Directors Meeting, ANA Papers, History of Nursing, Howard Gotlieb Archival Research Center, Boston University (original emphasis); The ideas were also reflected in the Report of the Task Force on Implementation of the Social Policy Statement, 29 September 1982, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.


441 Minutes, Conference Call, Task Force on Taxonomy, 5 & 6 March 1982, Irma Lou Hirsch Papers, Private Collection, Author.
be accomplished through collaboration. This change from a task force to a steering committee did two important things for the ANA: it positioned them to play a supervisory role of sorts over the development of taxonomies, and did so without overtly appearing to step on the toes of organizations such as NANDA that were actively pursuing taxonomy development.

The careful manner in which the ANA and the Congress for Nursing Practice treated NANDA was unusual for the organization. The ANA had, up to that point, rather contentious relations with other nursing interest groups. However, the organization was in a difficult position when negotiations ensued regarding the production and control of a taxonomy to describe nursing practice. Financial constraints forced the ANA to conduct more cordial relations with NANDA if one of the goals associated with the SPS—creating a taxonomy—was to be achieved. The ANA was not hoping for outright financial support; rather, it wanted to facilitate the direction of the taxonomy development without committing financial resources. The decision to change the name

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442 Julie Fairman illustrates several such relations. However, her chapter on NAPNAP is particularly poignant. See Fairman, *Making Room in the Clinic.*
443 Minutes, Steering Committee on the Classification of Nursing Practice Phenomena, 22 & 23 November 1982, Irma Lou Hirsch Papers, Private Collection, Author.
444 This was a stance developed over several negotiations with NANDA and evolved as the two organizations worked with each other to develop a taxonomy. Diagram, ANA/NANDA Relationship for the Adoption of the Nursing Diagnosis Component of the Nursing Practice Classification System, 18 September 1986, Irma Lou Hirsch Papers, Private Collection, Author; Chronology and Notes on Meetings of Staff Task Force on Classifications for Nursing Practice, August 1987, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee; Summary Report of Meeting Outcomes, NANDA/ANA Collaborative Group on Taxonomies/Classifications of Nursing Diagnosis, 15-16 May 1987, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee; Recommendations to Organizational Boards, NANDA/ANA Collaborative Group on Taxonomies/Classifications of Nursing
of the ANA group supporting taxonomy development and call it a steering committee was one means of appeasing NANDA, as was the decision by ANA to support a unified taxonomy.

A uniform taxonomy meant the ANA had to either decide to make its own taxonomy and attempt to mandate its use, or designate an existing taxonomy as the classification for use in describing nursing practice. The ANA did not have the power to take such action, so neither of these choices was a viable option. If the ANA tried to take either route, it risked the “death of the [taxonomy] development,” something unacceptable to the leadership of the Congress for Nursing Practice. Due to the ANA’s extreme financial problems, the congress could do little else but appear to facilitate the growth of a taxonomy initiated by other groups and organizations.

The area where the Congress for Nursing Practice and the SPS Implementation Task Force believed they had opportunity to exert greater influence over nurses was in the dissemination and acceptance of the SPS. One of the strategies employed by Lang, who was now the chair of the Implementation Task Force, was to solicit support from a number of fairly well known educators in nursing. She began requesting letters from individuals such as Margretta Styles, Dean of the School of Nursing University of California, San Francisco; Donna Diers, Dean of the Yale School of Nursing; Luther

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Diagnosis, 15-16 May 1987, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.

445 This was an initial decision made by the Steering Committee. Later, the organization would begin to consider a clearing house of sorts for nursing information sources.

446 The ANA Board of Directors felt that there would be another drop in membership after a brief reprieve and leveling off of membership losses.
Christman, Dean of Rush University School of Nursing; and Vernice Furgeson, Director of VA Nursing.\textsuperscript{447, 448, 449, 450}

For the most part, those Lang approached gave their support, but this was an odd strategy from the start. The discord caused by many of the statements in the SPS had to do with the fact that specialty organizations and nurses who were practicing NPs were not included in the creation of the SPS, nor did they feel their interests were represented by it. Now, as the ANA attempted to disseminate the SPS to practicing nurses, the organization was soliciting support from nurses removed from practice to help sell the SPS to the very nurses who felt excluded by the elitist tone of the document. This misstep reinforced growing disapproval of the ANA and its practices, and did little to stem the tide of criticism of the SPS.

Lang's request for support was part of the five-year master plan that included gaining support for the SPS in nursing education so that the next generation of nurses would come to accept the document. Under the category of nursing education, one of the draft versions of the strategies directed educators to “determine where and how in

\textsuperscript{447} Norma Lang to Margretta Styles, Dean, University of California San Francisco 13 December 1982, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
\textsuperscript{448} Norma Lang to Donna Diers, Dean Yale School of Nursing, 3 January 1983, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
\textsuperscript{449} Norma Lang to Luther Christman, Dean, Rush University, 15 January 1983, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
\textsuperscript{450} Norma Lang to Vernice Furgeson, Director of VA Nursing Service, 10 January 1983, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
undergraduate curriculum to teach [the SPS]." Chairperson Lang reacted to this portion of the draft, noting to Hirsch that the bullet point was “too strong!” and that it seemed to “usurp faculty prerogatives.” This careful treatment of faculty by the task force, compared to the treatment of staff nurses and NPs, was astonishing. “Help practicing nurses understand nursing” was one of the stated goals of the SPS implementation, a statement that met with little concern from the task force despite its condescending tone.

With regard to NPs, the Implementation Task Force took a very different approach from the one used with nurse faculty. In a report to the Cabinet on Nursing Practice (formally known as the Congress for Nursing Practice), the task force illuminated ANA’s stance on specialization:

Up to a point, diversity is a constructive response to social change and increased professional capabilities. The diverse groups in nursing, however, must remind themselves or be reminded of their common mission, roots, and responsibilities. The sometimes contentious groups within nursing can be compared to tribes within a species. Tribes that deny the species do so at their own peril; the denial impairs the evolution of the species.

The report went on to address the role of NP:

Such adaptations in local practice are at best a collaboration between nursing and medicine toward possible increase in effectiveness and efficiency in the provision of health care. To incorporate local adaptations as a medical part of the larger

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452 Ibid.
whole of professional nursing through nurse practice acts is obviously illogical. It also connotes some substitution of nursing for medical practice and interprofessional competition, none of which are in the best interests of the public or in the interests of the evolution of either profession. For nursing in particular, it diverts energy that should be used in developing the potentials of nursing practice and of nursing as a national health resource.

These statements, along with the accompanying document *Definition of Terms: Further Elaboration of Terms in the Social Policy Statement*, were not well received.\(^{455}\)

The Georgia Nurses Association commented in a memo to the ANA that the strategy, “promotion of unity,” identified by the Implementation Task Force, was unclear at best, and that the “comparison of infighting to tribes” was unhelpful.\(^{456}\) Donna Nativio, a University of Pittsburg School of Nursing professor, wrote a letter to Jean Steel, one of the members of the Cabinet on Nursing Practice, in which Nativio voiced her frustration regarding the ANA’s apparent stance. She was responding to the following line in the report: “The reimbursement objective should not be payment for nursing performance of medical acts.”\(^{457}\) Nativio felt that the SPS “chastised [the] work of some nurses for expanding their scope of practice.”\(^{458}\) She also felt that the “language [was] offensive.”\(^{459}\)

Linnie Toney, a family NP and member of the Kentucky Nurses Association, also


\(^{456}\) The document was disseminated to the leadership of ANA’s state associations. Georgia Nurses’ Association to American Nurses’ Association, 14 June 1984, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.


\(^{458}\) Donna Nativio, University of Pittsburg to Jean Steel, 23 June 1984, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.

\(^{459}\) Ibid.
criticized the ANA, saying that she was “opposed to denying nurses reimbursement for medical acts” and found it to be a “grave injustice to deny [nurse practitioners] this reimbursement.”

Another letter, this one from Em Olivia Bevis and Charlene Hanson, directors of the Family Nurse Practitioner Program at Georgia Southern University, urged the Council to send the SPS back to committee for “massive revisions.” The two felt the SPS, in its current form, would “serve to further divide nursing.” They stressed the need for the ANA to have a “structure that supports those whose roles blur with others—for out of this role blurring develops new roles for nursing.” Both also thought that “equating specialty groups to species, species that need to be quiet” was offensive.

Even within the ANA, there was a growing dissatisfaction with the SPS. Martha Garcia, chairperson of the Cabinet on Economic and General Welfare, in a memo to the Implementation Task Force, logged the cabinet’s dissatisfaction with the implementation strategies, particularly the portion of the publication meant to “help practicing nurses understand nursing.” Maria Phaneuf, one of the authors of the SPS, also called for dramatic changes in the document. She had long pushed for a more progressive, inclusive

460 Linnie Toney Family Nurse Practitioner, Kentucky Nurses Association Member to Jean Steel, 19 June 1984, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
460 Ibid.
461 Em Olivia Bevis and Charlene Hanson, Directors, Family Nurse Practitioner Program, Georgia Southern University to Implementation Task Force, 11 June 1984, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
462 Ibid.
463 Ibid.
464 Ibid.
465 Martha Garcia, Chairperson, Cabinet on Economic and General Welfare to Norma Lang, 24 June 1984, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
stance on the NP role and better treatment of the staff nurse within the SPS. The Kentucky Nurses Association reiterated their objections to the poor treatment of staff nurses, or "technical nurses" as they were referred to in the SPS. Donna Nativio also commented that the language "referring to nurses without a BSN [as] less than professional [was] elite, and frightening."

Conclusion

Throughout this chapter, we have seen the divisive nature of an information practice designed to reign in nursing practice, while outwardly promoting unity in nursing. By its focus, the ANA SPS prioritized the practice of NPs over the practice and needs of its other members. Yet the SPS did not shape the work of any group of nurses; instead, it reaffirmed and determined the course of the ANA. Regardless of whether it was a misconception about, or an oversimplification of, the role of NP and the broader trend of specialization, the ANA failed to take advantage of the opportunities for nursing made available by the public’s expectation for skilled and knowledgeable nurses. Local collaborations between nurses and physicians, like ones referenced in the Implementation Task Force report, were not simply the result of the idiosyncrasies of a few nurses, but the growing demands of a public looking for an alternative to physicians for basic health care in general. This demand did not stop or even necessarily start with NPs, as the expectation on the part of the public was for skilled, knowledgeable nurses in general.

466 Maria Phaneuf to Irma Lou Hirsch, 13 April 1984, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
467 Board of Directors, Kentucky Nurses’ Association, 17 June 1984, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
468 Donna Nativio, University of Pittsburg to Jean Steel, 23 June 1984, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
Perhaps it was also growing public awareness of what nurses could do, and more important, what the public could do to help themselves.

Yet the ANA put all its organizational focus on one line of effort—gaining control over the NPs and their specialty organizations. This was not just a phenomenon of the 1980s; it also characterized the ANA’s standards of care and credentialing programs in the 1970s. Even though nurses who were not NPs were practicing in different ways, the ANA targeted NPs because they were the most visible outcropping of these changes in public expectations for nurses. The SPS was created as a document that the ANA could refer to when voicing its preference surrounding standards and credentialing as well as legal aspects of practice. The flawed assumption on the part of the ANA, and the bigger issue at play here, was not the treatment of the NPs by the ANA, however unfortunate and disrespectful it was. It was the assumption that the ANA alone owned the right to, and was therefore responsible for, defining nursing practice. In picking and choosing to include in the SPS only those elements of specialization that satisfied its own political agenda, the ANA ignored the realities of practice and, by proxy, the demands of the public.

This narrative about the SPS reflects the changing relationship between nursing and the public. While nurses have always been subject to patient expectations, up to this point, these expectations had largely been limited to the immediate relationship between a nurse and her patient. The SPS reflects a symbolic engagement with the public that had not previously been articulated. Even though the document largely represented the ANA’s internal concerns, there were portions that addressed nursing’s relationship to the public. The obligation of nurses to provide care that not only meets the patient’s needs,
but does so safely and with a sense of moral obligation, elevates the work to something more than just an occupation. It is this articulation of nursing's social contract where the task force and the ANA succeeded. When the SPS was released, the AMA had no comparative document. The SPS stimulated the AMA to reconsider its relationship with the public.
Chapter 4


After the passing of the 1965 Social Security Amendment that launched the Medicare and Medicaid programs, and subsequent additions to that law in 1972, the U.S. Government experienced dramatic increases in health care costs.\(^{469}\) Implementing these social services, which facilitated access for new patient populations (primarily the elderly and individuals with particular ailments such as kidney disease), contributed greatly to rising program expenditures. The initial setup of these programs had virtually no caps on spending. If a hospital wanted to raise profits, all the organization had to do was increase patient volume and the diversity of services offered. One question that grew more insistent as spending seemingly spun out of control was, what exactly were we paying for?

Under pressure to curb spending, the U.S. Congress passed a mandate establishing the Professional Standards Review Organization (PSRO). In this mandate, which accompanied the 1972 Social Security Amendment, Congress charged the PSRO with identifying criteria to appraise the care being delivered under the Medicare and Medicaid programs. This newly formed government oversight group began by first evaluating, and then creating, various information practices aimed at assessing health care services. These information practices held a twofold function: identify costs associated with care and determine the quality of care provided. Quality of care was defined in so many

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\(^{469}\) For an in-depth treatment of the economic issues surrounding healthcare during the twentieth century, see Stevens, *In Sickness and in Wealth.*
different ways that it is difficult to distinguish just one definition for the term, but the
PSRO chose to address the issue of quality and costs by creating standards of care.\footnote{470}

Standards of care were compilations of general treatment guidelines for a
particular type of patient (e.g., those needing hip replacement) and outlined what
information needed to be collected about a given service episode.\footnote{471} The guidelines
required that the information gathered consist of data about the type of hospital, the level
of care (e.g., intensive care, ward, outpatient), and what services were provided and by
whom (physician or surgeon). The intent was to determine the necessity of the various
treatments rendered to the patient, essentially controlling costs while ensuring adequate
care.

It is no surprise that physicians did not react well to the supervisory function
assumed by the PSRO.\footnote{472} Over the course of the PSRO’s history, various challenges and
pushbacks by the American Medical Association and other professional groups


\footnote{471} The standards were part screening tool, part outline of standard treatment for a given illness.

representing physicians caused ebbs and flows in the PSRO’s power.\textsuperscript{473} Perhaps most important is the PSRO’s role in fueling competition to identify and define information practices to be used for evaluating health care services.

One of the numerous information practices proposed during the time period was a Minimum Data Set (MDS). A MDS held particular appeal because, as the name signifies, it was the least amount of information needed to evaluate a given service.\textsuperscript{474} Most MDSs designed in the 1970s and 1980s were constructed to identify the services provided to patients and evaluate costs. Additionally, each data set needed to be useful for most, if not all, potential users, contain no duplicate data (i.e., data contained in another MDS), be reasonably easy to collect, and, as is the case with health-related data sets, protect the identity of patients.\textsuperscript{475}

With demand for data on the rise because of the need to evaluate costs, hospitals and clinicians alike faced dramatic increases in the time spent charting and addressing regulatory reporting requirements. Any opportunity to reduce that load and gain control over questions of what information should or should not be provided would be beneficial, and several groups began creating and promoting their own data sets. Any group whose data set was adopted would gain financial and political power. Although these data sets differed from the standards created by the PSRO, they essentially served the same evaluative function.

\textsuperscript{473} Manuscript, PSROs: Chariot of the Gods, by Micheal Hertel, Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.


\textsuperscript{475} The Department of Health and Human Services did not want data sets to contain duplicate data because of costs and because duplicate data hinders ease of use.
Despite the efforts of the PSRO and others mentioned above to develop various information practices to evaluate costs, healthcare costs were rising at such a rate that Congress was once again considering legislation to control expenditures associated with Medicare and Medicaid programs. This legislation flipped control from providers and facilities to payers. This forced the development of a different series of information practices to justify costs and demonstrate that the patients needed the services provided.\footnote{For a detailed explanation of the Prospective Payment System, see Rick Mayes, “The Origins, Development, and Passage of Medicare’s Revolutionary Prospective Payment System,” \textit{Journal of the History of Medicine and Allied Sciences} 62, no. 1, (2007): 21-55.}

\textbf{The Case of the Nursing Minimum Data Set, 1985–1990}

The following case details the activities of a small group of influential and up-and-coming nurses as they set out to identify a nursing minimum data set (NMDS).\footnote{A minimum data set is a collection of limited information organized into a series of defined categories.} The NMDS was a grouping of information that reflected nursing care delivered to patients, both in terms of cost and quality. The NMDS is an interesting case, as it is representative of an information practice that essentially intended to create an altogether different record of the patient’s office visit or hospitalization.\footnote{The existing record of a patient’s stay consisted primarily of an account of the activities and services provided by physicians. This record took different forms across settings and places where care was delivered, but did not usually reflect any nursing services provided on behalf of the patient. Nursing care was billed as part of the room fee and no specific record was kept as to the specifics of the nursing care delivered.} If the nurses succeeded in getting the NMDS adopted and disseminated, this alternative record would fully recognize that another provider besides physicians delivered essential care to patients, as it offered information about the work of nurses. Further, costing out nursing care made

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the work visible in terms that administrators and policy makers understood. With so much riding on this information practice, the negotiations that occurred over identification and selection of information for inclusion were understandably intense.

This chapter primarily covers the three key events associated with the creation of the NMDS, the preconference, conference, and postconference, that spanned the years 1983–1985. The preconference planning consisted of numerous meetings during which debates took place over who should control the NMDS production process. During the conference and postconference, participating nurses made momentous decisions about NMDS content, and some of these decisions led directly to the NMDS not being widely adopted. Lastly, in the five years after the conclusion of the NMDS postconference, one of the organizers, Harriet Werley made a series of attempts to disseminate the NMDS.479

**Background**

The Social Security Amendment in 1972 expanded insurance coverage for patients needing expensive medical services such as treatment for end stage renal disease.480 With this increase in covered patients came many expectations about the care delivered. Patients were beginning to feel empowered to make decisions about their care and to anticipate high quality care.481 This expectation manifested an anticipation of cure, access to all the latest technology, and skillful expertise not only from physicians but also from nurses. And, while cost evaluation on the part of hospitals and government

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479 Werley did this largely without any further communication or input from conference attendees.
480 Specifically dialysis and other treatments associated with end-stage renal disease.
481 This was also discussed in chapter 1 in some detail. Fairman, “If You Can’t Get What You Want You Get What You Need: Patients and the Rise of the Nurse Practitioner Profession in the 1970s.” Also see Tomes, “Patients of Health-Care Consumers? Why the History of Contested Terms Matters.”
sponsored programs was important, so was the need for hospitals to evaluate the quality of services delivered.

This need to evaluate both costs and quality of service prompted the development of two levels of information practices: those aimed at evaluating practice or service provision at the local level and those at the national aggregate level. Each level had its own approach to the problem of information, with locally derived practices focusing on streamlining data collection in order to evaluate and then improve timeliness of practice. There was, during this time, a plethora of charting tools introduced. Some of the more popular tools, several of which are still in use, were the SOAPE (subjective, objective, assessment, plan, and evaluation) charting format, the POMR (problem-oriented medical record), and the nursing process known as ADPIE (assessment, diagnosis, plan, intervention, evaluation). These tools served the function of identifying some of the care nurses and physicians delivered to patients, but also provided the means to deal with increasing complexity and messiness of practice.

Nationally, information practices were focused on making visible the work surrounding patient care. This was a necessary step for physicians and nurses alike if, under the new federally funded programs, physicians desired continued reimbursement for services and nurses desired the opportunity to cost out their services and determine staffing.

Specifically, information associated with treatment decisions that involved

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482 In chapter 1, several examples of the “local” information practice in the form of a nursing care plan were presented.  
484 In the nursing literature there was a general sense that if the actions nurses took on behalf of patients were captured, the ability to bill for those services would follow. We
use of specific levels of care, technology, or other types of billable services, provided the means to evaluate practice on an aggregate level. The information could then serve as a proxy for practice in terms of what was done for patients. Although the stated purposes of these information practices were quality assurance and cost evaluation (with control to follow), many, if not most, initially had to identify practice. To a certain extent, there was a void of information about the general types of services offered to patients.

Professional organizations such as the American Psychological Association (APA), government agencies such as the PSRO, and groups such as the American Hospital Association (AHA) were all working to develop information practices to fill the void and to evaluate services in terms of cost.\textsuperscript{485} It was during this time that the Department of Health and Human Services (DHHS) developed the hospital discharge data set, which was first put together in 1974 and then revised in 1979 and 1984.\textsuperscript{486}

Nurses were looking into designing a MDS as well. However, unlike the AHA or the APA, organizations that represented the political interests of their members, it was not the American Nurses Association (ANA) that took on the task of designing a NMDS. Throughout the development of the NMDS, the ANA was struggling to address its own budgetary issues and membership losses.\textsuperscript{487} These persistent problems kept the

\textsuperscript{485} The APA was designing a MDS; PSRO was developing its quality screens; and the AHA was working to develop a discharge data in cooperation with the Department of Health and Human Services.

\textsuperscript{486} Nancy D. Pearce, Statistician, Office of Program Planning, Department of Health and Human Services to Harriet H. Werley, 11 June 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.

\textsuperscript{487} See chapter 3.
organization preoccupied with staying viable, and limited its participation to reactionary position statements.

Despite the ANA’s forced disinterest in the development of information practices, many nurses working independently of the ANA sought ways to capitalize on both the public’s and government’s growing interest in health-related information. Numerous nursing conferences were held from the mid-1960s through the early 1980s that provided opportunities to address what direction, if any, nurses would take in developing information practices. Largely attended by nursing faculty and researchers, the National League for Nursing, the Conference for the Classification for Nursing Diagnosis, and other small professional meetings generated interest in particular areas (for example, nursing diagnosis) while others targeted general information system development.\textsuperscript{488}

One such conference related to the development of the NMDS was a 1977 event held in Chicago, Illinois.\textsuperscript{489} Conference planners marketed this invitation-only meeting as a research conference on nursing information systems.\textsuperscript{490} Sixty-three individuals, mostly nursing faculty, a few government leaders, and nurse administrators, met to discuss a

\textsuperscript{488} The National League of Nursing conference was held in 1976 and addressed issues related to public health management systems. The Classification of Nursing Diagnoses Conference was first held in 1973, then again in 1975, and focused on the production of a classification system for use in nursing practice.

\textsuperscript{489} Draft, Information Systems for Nursing Practice: A Conference Report, Margaret R. Grier and Harriet H. Werley, 9 January 1978, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.

\textsuperscript{490} Draft Letter of Invitation, 23 March 1977, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
variety of issues related to the computerization of health information.\textsuperscript{491} The stated purpose of the meeting was multifaceted: create a database for clinical decision making, identify a data set, name nursing-specific outcomes, address issues with other proposed information practices, for instance, the POMR charting tool, determine potential research directions, and tackle issues surrounding computerization.\textsuperscript{492} For the organizers of the conference, the intent was to stimulate action, but like most meetings there was mainly a great deal of discussion about the current issues associated with information.\textsuperscript{493}

Harriet Werley, one of the planners of that 1977 conference, coordinated the event along with colleague Elizabeth Grier.\textsuperscript{494} The two were attempting to capitalize on the increased attention on information practices and provide the one solution for nursing with regard to data collection. Unfortunately, conference planners failed to produce any substantial data collection product because the emerging problems associated with cost and measuring quality were just too new for them to decide what information should be


\textsuperscript{492} Harriet H. Werley, “Nursing Data Accumulation: Historical Perspective” 14-16 June 1977, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.

\textsuperscript{493} While Werley never stated outright, I believe based on comments she made throughout the NMDS preconference and conference meetings that she was dissatisfied with the lack of definitive action. Her frustration largely emanated from watching as other groups began production of various information practices, specifically the discharge data set created by the AHA and the DHHS.

\textsuperscript{494} Harriet Werley was associate dean for research and faculty member at the University of Illinois. Margaret Grier was an associate professor at the University of Illinois. Harriet H. Werley & Margaret R. Grier, ed. \textit{Nursing Information Systems} (New York: Springer, 1981).
included. The planners had to be satisfied with producing a book that highlighted current issues facing the development of nursing information systems.

Between the 1977 conference and 1983, there was a spike in activity surrounding the production of information practices.\textsuperscript{495} Soaring health care costs prompted Congress to consider new mechanisms to control spending. These mechanisms came, once again, in the form of requests for even more information. Previous attempts to control costs through oversight by the PSRO had failed to meet expectations, and Congress passed new legislation in 1983. This new legislation, known as the Tax Equity and Financial Responsibility Act, introduced the prospective payment system and Diagnostic Related Groups (DRGs).

Prospective payment provided a system of billing that classified hospital cases in to one of five hundred DRGs.\textsuperscript{496} This system pushed the standards approach, hyped by the PSRO, to a different level. It changed the billing practices of hospitals, forcing them to consider costs before the patient was treated. The intent was to reduce spending by limiting the number of covered services and reducing the patient’s length of stay.\textsuperscript{497} Payments were calculated using a hospital’s average cost and the statewide average cost of treating patients in a particular group. If a hospital’s fees exceeded the DRG payment, that facility essentially had to absorb the additional costs associated with a given patient stay.

\textsuperscript{495} The spike was brought about by an increased focus on costs and an impending decision on how to limit those costs. For more on this topic, see chapter 1.
\textsuperscript{497} Grimaldi and Micheletti, \textit{DRGs: A Practitioner’s Guide}. 
There were both critics and proponents of this new system. Physicians argued that the DRG payment mechanism took critical treatment decisions out of their hands and placed these decisions into the hands of hospital administrators. Decisions about patient treatment, for example, how long a patient stayed in the hospital or what types of interventions were used, would largely be made based on costs. Hospital administrators, on the other hand, felt confident that the DRG system would provide a means for improved control over hospital operations, but worried over the immense costs associated with reporting and streamlining services. ANA president Eunice Cole, in testimony to the Subcommittee on Health and the Environment, contended that the DRG system failed to consider the intensity and variety of nursing services needed across a patient’s stay. She also pointed out that the DRG system failed to consider differences between emergency and nonemergency treatment.

Despite protest, the DRG system moved forward and fueled a shift in thinking about information practices. Unlike the 1970s, when any information was important for billing, in this post-DRG era, for hospitals and providers to be financially solvent, they needed a reduction of information and tight control over services offered to patients. It was during this time period that Harriet Werley decided it was time to push for the identification of a NMDS. You’ll recall that Werley was one of the planners of the 1977

conference on nursing information systems, and one topic discussed was identification of a data set for use in nursing practice.

People, Places, and Identifying the NMDS

In the interim between the 1977 conference and the passing of the 1983 legislation, Werley had moved from her faculty position in Chicago to one at the University of Wisconsin–Milwaukee. Werley was nearing the end of a very long career in nursing. Her background was primarily military, where she excelled and moved to some prominence in the Army Nurse Corps. Thus, it is not surprising that her leadership style, as well as how she wielded her power, was very militaristic. She had a propensity and a preference for the command and control management structure that had served her well throughout her career.

In 1983, Werley once again sought out like-minded nurses to plan a conference, the purpose of which was to identify a NMDS. One person that she heavily relied on throughout the preconference planning was her dean, Norma Lang. Lang, who had agreed to co-chair the conference, had formative experiences marked by cooperation and collaboration, which was very different from Werley’s experience. Lang had practiced in an interdisciplinary group as part of a Regional Medical Program. She had become

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501 In October 1965 the Heart Disease, Cancer and Stroke Amendment (Public Law 89-239) authorizing the establishment and maintenance of Regional Medical Programs was signed. Its purpose was "to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training, including continuing education, and for related demonstration of patient care..." (Sec. 900, PL 89-239). Fifty-six regions were established, covering the nation, including Alaska, Hawaii, and Puerto Rico. Most programs were located at or near university medical schools.
accustomed to working alongside clinicians from a variety of different disciplines.\textsuperscript{502}  
She also had a significant history of working with the ANA and had just completed  
chairing the development of the ANA’s Social Policy Statement.\textsuperscript{503}

The NMDS preconference planning began nearly two years before the conference  
was scheduled. There was some discussion about holding the conference earlier than the  
summer of 1985, but difficulties with securing funding, one of two issues that occupied  
the group, prolonged the planning phase.\textsuperscript{504} The local database group, as Werley and her  
colleagues called themselves, had made numerous requests soliciting funding for the  
conference. Werley, using her long-standing connections, solicited funding from the  
National Center for Health Statistics, Weston National Center for Health Services  
Research, the U.S. Department of Health and Human Services, and the Division of  
Nursing, but all rejected the requests, stating that the NMDS was not a funding  
priority.\textsuperscript{505}

Despite difficulties obtaining financial support for the conference, planning  
continued. Many of the meeting’s discussions centered on issues of control. The group  
was designing this MDS for one general purpose—control of nursing practice through  
information. It was argued that the purpose of the NMDS was to manage practice by

\textsuperscript{502} Norma Lang, personal communication, May 17, 2007.  
\textsuperscript{503} See chapter 3.  
\textsuperscript{504} Minutes, Local Data Base Group, 19 May 1983; 27 June 1983; 11 July 1983; 25 July  
1983; 7 September 1983; 12 October 1983; 17 October 1983; 21 November 1983; 21  
December 1983, University of Wisconsin-Milwaukee, Harriet Werley Papers,  
unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.  
\textsuperscript{505} Jo Eleanor Elliot, Director, Division of Nursing, Department of Health and Human  
Services to Harriet H. Werley, 17 August 1983, Harriet Werley Papers, unprocessed,  
University of Wisconsin-Milwaukee, Manuscript Collection; Minutes, Local Data Base  
Group, 27 June 1983; 7 September 1983, Harriet Werley Papers, unprocessed, University  
of Wisconsin-Milwaukee, Manuscript Collection.
establishing norms, standards, and cost of nursing services.\textsuperscript{506} The group believed that dictating what information gets collected was a way to determine the priorities of nursing work. Because this control was so incredibly valuable, many heated discussions erupted at the local planning meetings about the future content of the NMDS. The nurses saw this as an opportunity to define nurses’ work through information, and because of this, each tried to advocate for his or her particular view of the profession via inclusion of specific data points. While Werley believed in the importance of information, she continually reminded the group that they were “not talking about establishing a professional identity.”\textsuperscript{507}

But the nurses working on the NMDS were trying to establish a professional identity. As mentioned in the early portion of this chapter, the NMDS was intended to create a different record of care, one that recognized that nurses delivered critical services to patients, itemized these services, and provided a means for payment for these services. Separating the nurse from the costs of the hospital room was a common refrain and emblematic of the group’s motivation to make nursing visible.\textsuperscript{508} Formal identification of nursing services was nonexistent in bureaucratic terms, so the potential power associated

\textsuperscript{507} Minutes, Local Data Base Group, 11 July 1983, University of Wisconsin-Milwaukee, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
\textsuperscript{508} It also demonstrated the group’s leaning toward acute care.
with the idea of the NMDS was substantial.\textsuperscript{509} Therefore, the individuals who participated in the meetings brought a significant number of expectations and ideas about what information the NMDS should contain.

One issue that had weighed down the Classification of Nursing Diagnosis (CND) conferences also emerged in the planning meetings surrounding the NMDS. As in the CND conferences, the question of whether to use a deductive or an inductive approach to classify ND made its way into discussions about the data set content.\textsuperscript{510} However, the majority of the preconference participants were less concerned with the issues of conceptual ordering and far more concerned with the economic implications of the NMDS information.

This difference in concerns was due, in part, to the demographics of the NMDS planning group. Unlike the group associated with the CND, no theorists were involved with the NMDS, as the planning committee consisted mainly of faculty and nurse administrators.\textsuperscript{511} This was a logical shift in participants not only because nurse administrators would largely be responsible for uptake of the NMDS, but also because the intended use of the NMDS was cost and quality evaluation.

The demographics of the planning group partially explain why the main focus of debate centered on economic and research measures for the data set. One of the more

\textsuperscript{509} Portions of the nursing workforce were, by this time (1985) recognized independently within health care organizations in so much as they were able to bill and generate revenue. These workers were NPs.

\textsuperscript{510} Ibid. There were a number of individuals, such as Marjory Gordon and Phyllis Kritek, who were involved with both the CND and the NMDS. Phyllis Kritek served on the planning committee for the NMDS and was a highly visible member of NANDA.

\textsuperscript{511} The planning group had one administrator and seven faculty members. In addition to the committee members, Roy Simpson, a hospital administrator for a Cleveland-area hospital, and other nurse administrators participated throughout the preconference stage.
heated discussions surrounded the review of commissioned papers. It was decided early on in the planning phase that select invited attendees would be asked to present papers on particular topics related to the NMDS. The planning committee collected and vetted forty-three papers prior to the conference.\textsuperscript{512} Two papers in particular, both of which addressed the use of nursing resources, drew animated conversation at the January 1984 meeting of the planning committee.

One of these controversial papers identified variables for measuring the cost effectiveness of nursing care delivered.\textsuperscript{513} Essentially, the paper proposed a number of measures that examined nursing services in terms of cost, and therefore framed potential solutions in terms of cost cutting.\textsuperscript{514} Such measures would be handy for nurse administrators who were responsible for hospital-wide budgets, but the measures were also a risk. Framing nursing care in terms of costs, rather than profit, placed these services at risk each time budgetary crises emerged. This, along with the fact that these measures were not singularly nurse dependent, prompted discussion over the usefulness of these data points.

The second paper, and the more political of the two, examined measures to assign a monetary value to nursing services delivered to the patient, making nursing care visible

\textsuperscript{512} Minutes, Local Data Base Group, 19 January 1984, University of Wisconsin-Milwaukee, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
\textsuperscript{513} Draft, Minimum Variables in Cost Effectiveness of the NMDS, no author, 1984, University of Wisconsin-Milwaukee, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection. I believe these papers were not identified so that the group could vet them without consideration of the particular author.
\textsuperscript{514} For example, costs determined by the number of medications administered, the hours of nursing care needed, etc.
in terms of revenue. The only other providers that were viewed in this manner were physicians and surgeons. For the nurse administrators, this was a double-edged sword. If their areas of responsibility could demonstrate profit, administrators would have more power within their respective organizations. In addition, if hospitals or government payers collected data on the cost of nursing services across the country, nurses could use the information to change the dynamics of state and national negotiations about health care spending. Alternatively, the prospect of selling the idea of data collection to hospitals or government payers was limited for the very same reasons: it would lessen the bargaining power of other providers, namely physicians, who largely lay claim to revenue generation, and force hospitals to negotiate with nursing. Despite the political nature of the proposed paper, it was accepted as one of thirty to be presented at the conference.

However, it was unclear whether there would be a conference at all. The planning committee continued to search for funding throughout the spring and summer. Conference planners solicited financial support from the Robert Wood Johnson Foundation and the Health Care Financing Administration, but both declined. Early in the fall of 1983, Roy Simpson, one of the members of the planning committee, suggested

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515 Draft, Minimum Variables in Costing Out Nursing Care, no author, 1984, University of Wisconsin-Milwaukee, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
516 Minutes, Local Data Base Group, 19 January 1984, University of Wisconsin-Milwaukee, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
that the group seek funding from Hospital Corporation of America Foundation.\footnote{518} Werley quickly pulled together a conference grant application and sent it off to the organization.

While funding woes continued, the planning group focused on further selection of potential information to include into the NMDS. The nurses reviewed existing MDS for ideas about what information to include in theirs. It was during this review that the NMDS nurses first ignored what would become a formidable issue: the fact that the data set proposed by Werley and colleagues was provider-specific. The opportunity to address this issue arose during the planning group’s review of the APA’s MDS, a data set abandoned because it was provider-specific.\footnote{519} The DHHS fueled the creation of MDS by favoring development of patient-specific, and in some cases, site-specific MDS. This made sense because the government agency was attempting to evaluate costs of services rather than the costs of specific providers such as nurses or physicians.

Still, each of the data sets sanctioned and collected by facilities for the DHHS did contain provider information (either physician or surgeon). So, although the expectation that labeling the data set “nursing specific” made the information no more provider-

\footnote{518} Roy Simpson was director of Hospital Systems Support, Information Systems, Hospital Corporation of America. Minutes, Local Data Base Group, 7 September 1983, University of Wisconsin-Milwaukee, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.

\footnote{519} According to the information Werley had, the APA database was abandoned because of a lack of funding for provider-specific data sets. However, it was likely because the APA was in the midst of undertaking a revision of the Diagnostic Statistical Manual. This version was one of the more controversial revisions and took a great deal of the organization’s resources. See Kirk and Kutchins, \textit{The Selling of the DSM}. Werley’s information was obtained from the Minutes, Local Data Base Group, 21 November 1983, University of Wisconsin-Milwaukee, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
specific than the ambulatory or discharge data sets promoted by the DHHS, the data
set did not conform to the commonly understood standard. The idea of removing the
“nurse” identification embedded in the data set was not well received, especially by
NMDS co-chair Werley, who halted any discussion on the matter.\(^{520}\)

In January of 1984, the planning committee revisited the Hospital Corporation
funding application.\(^{521}\) Werley had contacted Simpson numerous times to query him on
the status of the application and Simpson had not replied. Werley’s frustration with the
funding situation showed in her communications to the planning group. This frustration
was understandable because the apparent momentum that had fueled the identification of
information practices like the NMDS had stalled with the rollout of the DRG program.
Hospitals and providers were busy dealing with the details of the new DRG billing
procedure, and organizations that might have supported the conference were instead
evaluating this new system.

During this time, Werley continued to draw financial support from the University
of Wisconsin in the form of secretarial support and workspace. These funds were
becoming a point of contention between Werley and Lang. Werley expected the school to
fund her activities, but Lang, as dean of the school, was under increasing pressure from
other faculty members to use the school’s funds more democratically.\(^{522}\) As the

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\(^{520}\) She did so because there was a strong, persistent theme of nurse independence that
seemed to fuel many of the decisions.

\(^{521}\) Minutes, Local Data Base Group, 19 January 1984, University of Wisconsin-
Milwaukee, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee,
Manuscript Collection.

\(^{522}\) Norma Lang, personal communication, May 17, 2007.
conference drew closer, Werley's use of resources increased, and the school continued to support her despite objections.

Later in the year, DHHS's revision of its Hospital Discharge Data Set occupied the planning group discussions. Conference planners were interested in two major revisions of physician identifiers: one that split the attending physician and surgeon into separate categories and one that indicated the type and date of procedures. The latter revision included a notation about the risks associated with the surgical intervention. These risks were identified by the categories procedural, anesthetic, or specialized training. These physician identifiers generated discussion about how nurse identifiers would be used in the NMDS.

The opportunity to differentiate the type of nurse delivering care to patients was important. The creators of the NMDS wanted to distinguish between registered nurses and those who were unlicensed, but they also wanted to identify nurses who were

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523 The database contains information on all discharges regardless of payer status including patients without insurance coverage. Data elements in the public data set include International Classification of Diseases, Ninth Revision, Clinical Manual (known as ICD-9-CM) diagnosis and procedures codes, gender, date of birth, admission date, discharge date, admission priority, length of stay, discharge status, total charges (based on specific items such as prescriptions), admission source, payer source, and county of origin.

524 Minutes, Local Data Base Group, 31 May 1984; 24 August 1984, University of Wisconsin-Milwaukee, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection; Edward N. Brandt, Jr., Assistant Secretary for Health, Chairperson, DHHS Health Information Policy Council to the Secretary, 25 July 1984, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection; 1984 Revision of the Uniform Hospital Discharge Data Set, U.S. Department of Health and Human Services Health Information Policy Council, July 1984, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.

525 Minutes, Local Data Base Group, 31 May 1984; 24 August 1984, University of Wisconsin-Milwaukee, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
prepared at the diploma, associate, baccalaureate, and master's level as well.\textsuperscript{526} This was a very politically charged notion and a difficult one to mandate in terms of data collection. Unlike physicians or surgeons, who took care of patients across a hospitalization, a patient might receive care from numerous nurses and others supervised by nurses, such as nurses' aids.

Furthermore, identifying patient risk in terms of nursing care delivered was also a challenge. The planning group debated several proposals that argued for one or another mechanism for risk evaluation, with all proposals framing risk in terms of patient acuity.\textsuperscript{527} Patient acuity was defined somewhat differently depending on when the evaluation was completed and by whom the tool was designed, but generally speaking the tools attempted to measure the amount of nursing care needed by a patient. The planning group reviewed several popular acuity tools, but none were chosen. All involved with the planning group did, however, agree that a risk evaluation measure would be included, and the decision was tabled until the conference.

In December of 1984, conference planners finally received good news regarding funding. The Hospital Corporation of America Foundation agreed to partially fund the event with a conference grant; these funds were in addition to the University of Wisconsin School of Nursing support already being used by the planning group.\textsuperscript{528} In

\textsuperscript{526} The administrators on the planning committee resisted this, preferring instead to support the hours of (generic) nursing care consumed by patients as the measure. They feared that identifying the type of nurse had the potential to limit their decisions to use less costly staff if links were made between improved patient outcomes and higher educated nurses.

\textsuperscript{527} Ibid.

\textsuperscript{528} HCA financing was $103K. Minutes, Local Data Base Group, 6 December 1984, University of Wisconsin-Milwaukee, Harriet Werley Papers, unprocessed, University of
addition to these two major funding streams, the IBM Corporation, contacted through
Werley’s old military connections, was also brought on as a small sponsor and agreed to
provide computers for use during the conference.\textsuperscript{529}

\textbf{NMDS Conference, May 15–17, 1985}

The NMDS conference was held in Milwaukee. Conference planners extended
invitations to a select group of sixty-five individuals, including nurses, information
systems experts, and health records specialists.\textsuperscript{530} Sixty-four of the invitees attended.\textsuperscript{531} In
the conference proceedings published later in the year, Werley gave the impression that
the attendees were a diverse group that included clinicians, administrators, researchers,
and faculty, and that this group represented the concerns of staff who would be called
upon to collect a large portion of the information required by the data set. However, the
only three clinicians who attended were advanced practice nurses and likely not the type
of nurse responsible for collecting information. Essentially, the makeup of the group was
not so different from that of the CND: elite and highly educated nurses, none of whom
could reasonably be considered an average nurse.

Werley and Lang opened the conference with plenary remarks. During her
address, Werley reviewed the planning committee’s work and highlighted the main

\textsuperscript{531} List, Task Force Groups, NMDS Conference, no date, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
challenge associated with the creation of the NMDS: meeting the needs of multiple data users. This was certainly a challenge, as the NMDS planning group had determined that the data set was intended for use by five different clinical sites: home health, ambulatory care, primary care, long-term care, and acute care. One data set for five service areas.

To put the scope of this data set into perspective, recall the discussion throughout previous chapters about the newly adopted skills, tools, and knowledge that nurses used. Nurse practitioners were diagnosing and treating patients, and staff nurses in specialty areas were increasingly intervening on patients’ behalf, often relying on standing orders and their independent decision-making skills, rather than physician interaction. The important point, as it relates to the NMDS, is that nurses adopted the various skills, tools, and knowledge needed to execute these activities, and these skills were variable not only within a given clinical area such as acute care, but most certainly across different service areas. If the NMDS was to be useful, it would have to be relevant not only across this variability, but also to the different types of nurses using the information practice.

Perhaps Lang was more sensitive than Werley to the challenges that faced the NMDS if the creators did not take into consideration the needs of the nurses who would be collecting and using the information. Lang’s opening comments reflected what she considered the biggest challenge facing participants, that of achieving consensus in an era

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of specialization and differentiation.\textsuperscript{534} Her statements certainly reflected both her experiences in writing the ANA’s Social Policy Statement (SPS) and the realities of practice. For all intents and purposes, the NMDS was moving in the opposite direction from that of nursing and health care, which were moving toward specialization. Lang, while certainly supporting the work of the NMDS, made it very clear that the time ahead would be challenging.

The remaining portions of the conference were organized around thirty papers commissioned by the planning group. Those participants who presented papers addressed different elements of the NMDS, including a wide range of topics such as data set integration, regulatory requirements, and general upkeep of the MDS, once identified.\textsuperscript{535} Werley portrayed these papers as representative of each presenter’s individual perspectives, but conference planners had actually vetted all the papers (and in some cases heavily edited them) prior to acceptance.\textsuperscript{536} The papers were used as jumping-off points for discussion about the NMDS content, and participants reached a consensus rather quickly with regard to the general types of data acceptable for inclusion.

**Demographic Task Force**

\textsuperscript{534} Opening Remarks, Norma Lang, 15 May 1985, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.

\textsuperscript{535} The papers were mailed out to participants ahead of time and each session was then a discussion/review of the issues addressed in each document.

From there, task forces were formed around each of the six topic areas: demographics, assessment, diagnosis, intervention, outcomes, and acuity/intensity.\textsuperscript{537} It is here, within the task forces, that participants addressed the most contentious issues of the conference and made critical decisions. One of the main points of contention was what should be included in the demographic data. The task force, chaired by Joyce Anderson, a conference participant and administrator, had selected a patient identifier, medical diagnosis, sex, race, ethnicity, date of birth, and so forth, as demographic items.\textsuperscript{538} These data points were reasonable inclusions, except for the fact that each point was duplicated in other data sets.

One of the main criteria when creating a MDS is that each set contain original information not possessed by another. For example, two of the data sets created by the DHHS were widely in use at the time of the conference, the Ambulatory Care Data Set and the Uniform Hospital Discharge Data Set. These data sets contained information that the nurses decided to replicate and keep in the NMDS.\textsuperscript{539} So right from the start, the NMDS was in violation of a generally accepted standard for information of this type.

\textsuperscript{537} List, Task Force Groups, NMDS Conference, no date, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
\textsuperscript{538} Joyce Anderson was a coordinator of patient care systems, memorial medical center, Long Beach, California Report, Demographic Task Force, 16 May 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection; Demographic Task Force Consensus Statement, Session 3, 17 May 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection; Minutes of Task Force on Demographics, Session 1, 17 May 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
\textsuperscript{539} In a background file kept by Werley, she created tables that compared the NMDS to both the ambulatory care and hospital discharge data set. The table illustrated the duplicate data. “Comparison of 1972 and 1989 Ambulatory Care Data Set” and “Comparison of the Nursing Minimum Data Set and the 1974 and 1984 Uniform Hospital Discharge Data Set,” 27 February 1990, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
Many of the attendees argued for dropping from the data set the patient, facility, and medical demographic data, but Werley would not hear of it. Werley, with some support, dogmatically pushed for the inclusion of all demographic data regardless of whether it was duplicated elsewhere.

This decision was largely motivated by professional pride. This desire to make nursing a visible entity in bureaucratic terms was a very strong motivator, but also a detriment. The DHHS basic standard for MDS information practice was very clear—no duplicate data. MDSs were supposed to be designed to complement one another, not replicate each other. This insistence that all demographic information be included created built-in difficulties for anyone considering adopting this information practice. For hospitals, it meant that the burden of information collection would not be lessened by the adoption of the NMDS, but possibly increased. Further, by including duplicate data, the nurses involved with the NMDS gave a ready-made politically correct reason for government agencies to reject this data set when asked to consider it. Despite these very straightforward issues, the participants, under Werley’s insistence, moved forward with the inclusion of the data.

Also addressed in the demographic task force meetings was the problem of selecting a mechanism to identify the nurse providers who were involved with a patient’s service use. Again, the scope of the data set forced inherent problems to the surface and made the task challenging. Because the NMDS was to be used in five different service areas, identifying a single data point (or even a cluster of data points) to recognize the nurse provider was nearly impossible. The task force was keen to identify NPs, but also

540 See FN 578.
had to consider other types of providers in areas such as long-term care, where either
a registered nurse or unlicensed personnel (e.g., a nurse’s aid) delivered the majority of
care. The NMDS creators were faced with first identifying the type of nurse caring for the
patient and then deciding how many of the nurse providers should be identified.

Unlike physicians, whose episode of care extends across a patient’s service use or
whose services are limited to discrete interventions, nurses’ work is not so easily
anchored to a single patient or point in time. Patients rely on nurses for 24-hour care, so
logically, it takes more than one nurse to care for a hospitalized patient. If the nurses
designing the NMDS wanted to capture the care delivered, they would need to decide
whether they were going to give each nurse a provider number, or group types of nurse
providers together by skill level. The decision was made to identify a primary nurse for
an episode of care and was ultimately geared toward identifying nurses with greater
responsibility, for example, NPs.

Assessment Task Force

The assessment task force started its session by developing a consensus statement
stressing the importance of the information collected during the course of a physical
exam. The group noted that patient information generated from physical assessment is
the foundation of the nursing information system. This statement was well accepted
among the nurses involved with the NMDS, but it was also an odd statement to make.
The purpose of the NMDS was to identify the minimal amount of information needed to
evaluate services provided to patients, not create a nursing information system.

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541 Nursing Assessment Group Consensus Statement, 17 May 1985, Harriet Werley
Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
The participants' and Werley's confusion about the purpose of the NMDS was due, in part, to residual ideas from the 1977 Nursing Information conference (mentioned earlier in the chapter) spilling into this one. The purpose of the 1977 conference was to design a nursing information system that included, among other types of information practices, a MDS. However, the confusion of purpose also stemmed from a strong desire to make nursing visible. The need to change the current level of nurse identification through information collection meant that nurses involved with the NMDS were constantly pushing the purpose boundaries of the information practice on which they were working. The nurses involved wanted the NMDS to be a decision-support system, used in real time, as opposed to a data collection tool used to harvest information after services were delivered. In that way, the NMDS represented what information the nurses wanted to see collected, irrespective of whether the information was used to evaluate services.

Because of the ambitions of the nurses embedded in the data points selected, assessment was an important issue for the creators of the NMDS. As mentioned in chapter 1 and some of the subsequent chapters, nurses were performing physical examination (called assessment in nursing) more frequently, and the uptake of this skill reflected nurses' changing responsibilities. Recall too that the ways in which nurses applied this skill was not consistent within a given institution, and certainly not across various institutions. Attempting to standardize the information collected about the patient during a physical examination basically went against the general purpose of the skill—

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542 This was seen throughout the reports made by the task forces and general group discussion surrounding the presented papers.
identifying an individual patient’s health issue(s). Standardization also went against the trend of variability of physical exam adoption within nursing. Standardizing something that was anything but standard meant that the NMDS ran the risk of not being a viable information choice.

Moreover, the Assessment Task Force was trying to choose from among four standardized physical examination forms: a checklist, Gordon’s Functional Health Patterns, the Classification of Nursing Diagnosis Taxonomy, and a five-page general health assessment form from the University of Iowa.\textsuperscript{543} The task force, using the various assessment categories from each of the samples, tried to come up with a list of around fifteen items. The difficulty they experienced was evident in their report to the main group. Anderson, the task force chair, highlighted difficulties with selecting items to represent physical exam information relevant across the five settings where the NMDS was to be used.\textsuperscript{544} The task force struggled to select data points that made sense for a medical-surgical patient, but also worked for that same patient in critical care, long-term care, or ambulatory care.\textsuperscript{545} Anderson continually returned to the idea that the NMDS should support nurse decision making in the variety of settings, even though again, that was not the function of a MDS. In the end, the NMDS creators decided to drop

\textsuperscript{543} Nursing Assessment Task Force Report, 17 May 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
\textsuperscript{544} Nursing Assessment Task Force Report, 17 May 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
\textsuperscript{545} For example, the general categories for assessment were as follows: biophysical health, and 10 “problems,” nutritional, elimination, sensory function, neurological, circulatory, respiratory, emotional, social, cognitive, and health management. Concern was raised over how these categories would apply to a typical medical-surgical patient and the group suggested adding stress, anxiety, fear, and depression. This addition of other areas continued through ambulatory care, home health, etc.
assessment from the data set altogether, opting instead to place this information into a clinical abstract.

The clinical abstract was fast becoming an additional information practice being developed by the group. At this point in the conference, the purpose of this clinical abstract might be best defined as an information catch-all, as it was the category where any information that did not fit easily into the standardized NMDS was placed. The abstract was also intended to give some context for the information located within the data set, functioning like a clinical story that chronicles the patient’s episode of service. For the time being, the task force left the general category of assessment information in the abstract, as there was no discussion about what specific information to include.546

**Diagnosis Task Force**

In turning to the Diagnosis Task Force chaired by Christine Tanner, issues that plagued the creation and dissemination of the CND crept into discussions on the use of nursing diagnosis (ND) in the NMDS.547 The definition of ND selected and approved by the Diagnosis Task Force was the same statement about ND found in the ANA’s SPS. The statement defined nursing practice as consisting of treatment of patient’s response to illness, not the illness itself. That statement was a highly controversial one, especially for nurses in advanced practice roles. Nurse practitioners and other nurses affected by the need for specialization saw the ND definition as a step backward, yet despite this

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546 Ibid.
547 Tanner went on to work with Patricia Benner and develop Benner’s work on nursing skill/knowledge acquisition. Nursing Diagnosis Task Force Report, 17 May 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
opposition to the definition, and ANA’s removal of the statement from the SPS, the NMDS nurses accepted it without much discussion.

**Assessment and Diagnosis Task Force Joint Report**

The topic that generated the most discussion was the question of what specific NDs, out of the numerous sets available, should be included in the NMDS. Because the creators of the NMDS agreed that ND was the end product of assessment, conference organizers asked both the Assessment and Diagnosis task forces to work together to address this issue. However, the two task forces could not agree. The diagnosis group saw significant differences between assessment categories and ND, whereas the assessment group did not.\(^{548}\) The Assessment Task Force wanted 14–16 classification categories from which to select a diagnosis for a particular patient, rather than using a specific ND. For example, there were three general categories of assessment: functions, behaviors, and conditions, all of which broke into subcategories of data. The subcategories were things such as self care management, emotion, cognition, and so forth, and would be what was marked or logged as the category assessed for the patient. The diagnosis group, in contrast, wanted the specific ND identified, despite that, for a given patient, multiple ND were often used and changed across the patient’s service use. Moreover, the specificity of the ND (when compared to the generality of the assessment categories) was problematic because it left little room for those homegrown ND that facilities actually used.

\(^{548}\) The statement was discussed at the conference but the draft was sent to Werley about two weeks later. Nursing Diagnoses Task Force, Nursing Assessment Group Consensus Statement, 5 June 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
Why all this focus on identifying a particular ND? The Diagnosis Task Force included many influential members of the North American Nursing Diagnosis Association (NANDA), the organization responsible for creating the Classification of Nursing Diagnosis.\textsuperscript{549} If you recall from that case, NANDA was having difficulty not only identifying an organizing framework, but also keeping control over the production process for ND. If individual ND, rather than a classification of ND, were promoted, NANDA would be able to continue pursuing its preferred organizing framework for its taxonomy. The system to classify nursing assessment data as proposed by the NMDS Assessment Task Force did not reinforce NANDA’s chosen framework that used Rogers’s Theory of Unitary Man.

The Assessment Task Force took a different approach, modeling the organization of ND around categories that cut across the different service settings the NMDS was meant to represent. For example, the self-care category and the assessment data included in that category would be different if the patient was hospitalized versus at home using home health services. This approach also gave the NMDS some flexibility to include ND generated from other nursing groups, such as those working on the Omaha system.\textsuperscript{550} Of course, being open to consideration of other ND classifications was threatening to the NANDA group, which was trying to gain recognition from the ANA as the organization responsible for production and approval of ND. Conference organizers, who had also attended some of the NANDA conferences, did not want to see the NMDS meeting

\textsuperscript{549} List, Task Force Groups, NMDS Conference, no date, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection

\textsuperscript{550} The Omaha System was used in home health care services. Karen Martin was one of the individuals who created the system and she attended the conference.
derailed, so they tabled further discussion, intending to revisit the issue at the postconference meetings.\footnote{Minutes, Session 3, 17 May 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.}

**Intervention Task Force**

Karen Rieder, chair of the Intervention Task Force, had overseen the development of sixteen categories of nursing interventions during the conference.\footnote{Karen Rieder worked for the VA system, a system that during this time was revamping its information practices.} While this topic and its associated subcategories did not generate much discussion, one interesting item was removed early on from the list of interventions: monitoring of equipment.\footnote{Intervention Task Force, Diagram of NMDS Contents, 17 May 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection; Intervention Task Force, Report on Nursing Intervention Task Force, Final, 17 May 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.} Use of monitoring equipment as part of patient care was growing at a rapid pace, and nurses were not only expected to be able to use a given piece of equipment, but also understand what actions to take based on the information generated by that tool. Even technology previously used by nurses, for example, blood pressure cuffs, were now used differently or more frequently as monitoring tools. In other words, nurses' time was increasingly occupied with not only operating this equipment, but also recording and acting on the information these tools generated.

Since monitoring equipment is used to gather information, and that information was often used to assess patient condition, the NMDS group logically subsumed this topic under surveillance, a category that encompassed physiological and psychological assessment. What is interesting about this category is that the creators of the NMDS
failed to recognize that just this one topic represented a mountain of data work for the average nurse. This omission reflected not only the academic and administrative composition of the task force, but also a subtle resistance to the technology. Superficially, the technology application was equated with a task orientation to the work, something the NMDS group opposed. The group continued to identify additional data points without much consideration of how the sheer volume of data would influence the work of nurses.

**Outcome Task Force**

The Outcome Task Force defined the outcomes associated with nursing care as nursing treatment's influence on consumer health status. Barbara Given, the task force chair, presented the three general categories subsumed under health status: role resumption, health management, and activities of daily living, or ADL. Role resumption attempted to measure a given patient's ability to resume his or her job, health management examined a patient's ability to manage his or her illness, and ADL considered how well a patient was able to execute personal hygiene, feeding, and so forth. Both the ADL and health management indexes had three measures associated with the category: independent, interdependent, and dependent, with role resumption having the qualifiers of delayed, immediate, or adaptive.

On the surface, the risk was minimal that the data set would be rejected because it required collection of these categories, as various health care services were already

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collecting most of the categories. For the most part, the task force viewed the three categories with a practical lens, with only one major reservation: if these outcomes were associated with nursing care, how then was the influence of the institution and other professionals involved with patient care to be separated out? The gap raised this question, in part, because just like the nurses involved with NANDA, the nurses working on the NMDS wanted to differentiate nursing care from medical care.\(^{556}\) This desire for recognition came with a series of assumptions about the nature of both medical and nursing care, the primary one being that medical care rendered by a physician was framed by existing data sets as independent of outside influence and attributable to only one person, whereas the nursing care was subsumed in the room costs, and involved more than one nurse for any given patient. For now, the task force accepted the categories and moved on to the final section of the NMDS.

**Acuity/Intensity Task Force**

Sue Ellen Pinkerton chaired the Acuity/Intensity Task Force that met in two sessions over the course of the conference.\(^{557}\) In the first session, the task force produced a general definition of acuity/intensity: the amount and level of nursing resources an individual patient consumed in a single episode of hospitalization, day of stay, or encounter.\(^{558}\) The several qualifiers defining *episode* were necessary due to the scope of the NMDS, which included 5 service areas. However, the qualifiers were also a point of confusion because the NMDS group was using acuity/intensity, a largely hospital-based

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\(^{556}\) Ibid.

\(^{557}\) Pinkerton was a nurse administrator who went on to be the Chief Nursing Officer for the University of Florida Medical Center in Gainsville Florida.

\(^{558}\) Nursing Intensity Group Consensus Statements, 17 May 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
measure, to represent service use in areas such as home health, primary care, and long-term care, essentially making it difficult to identify a single measure of time.

Also discussed under the umbrella of acuity/intensity was the caregiver’s skill level. Although the question of how and where to include skill level had already been debated under the demographic category, it was revisited here because of the assumption that the sicker the patient or the more complex the management, the higher the skill level required of the nurse. Again, while this conceptualization of service use worked well in the hospital, it did not necessarily apply in the other areas covered by the NMDS. Furthermore, it did not take into consideration nurses not directly involved with patient care activities, for example, nurse administrators or case managers, nor did it account for nursing care delivered by more than one type of nurse. As with most of these discussions where the answer was not clear, Werley stepped in and made the decision. In this case, she determined that staff mix would be determined by agency, tabling any further discussion to the postconference.

Close of the NMDS Conference

In the interim between the close of the first NMDS conference in May of 1985 and the September 1985 postconference meeting, participants who presented papers were again asked to revise and resubmit their work to Werley for review. She intended to solicit interest from various nurse-friendly academic book editors in the hopes of publishing a volume of conference proceedings. Despite the apparent progress of the

559 Ibid.
group, the problems that began in the preconference planning phase played a greater role in the months leading up to the postconference. Werley’s leadership style had weighed heavily on the outcomes of the conference, as she had pushed for conformity rather than consensus with each task force presentation. This approach also added to the existing stress between Werley and Lang, as the latter gravitated toward a more consensually derived product.

Werley’s leadership approach was perhaps most clearly apparent in her editing style, which included a broad editorial purview and an acute attention to content, due dates, and general details of the manuscripts submitted to her.\(^{561}\) It seemed that, after the close of the conference, Werley had the sense that the data set was getting away from her, so she responded by tightening control over the remaining NMDS communications and meetings.\(^{562}\) While this strained her relations and collaboration with the authors (most submissions included profuse apologies each time an author turned something in for review), Werley’s manner was perhaps most troubling for Lang, Werley’s coeditor, who bore the brunt of it.

A continual stream of handwritten and typed letters from Werley flooded Lang’s desk. Werley tracked when a manuscript was delivered to Lang, when it was returned, and to what degree the editing was satisfactory. Werley also sent detailed notes to Lang

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\(^{561}\) Werley had multiple tracking forms and was continually writing the authors after even just a few short days beyond her set due date.

\(^{562}\) Many of the participants went on to develop different parts of the data set and explicate the subsections. For example, the contingent from the University of Iowa worked on and eventually developed the Nursing Intervention Classification. However, Werley was less troubled by these developments and more focused on how the data set as a whole was being promoted. The requests to discuss and explain the data set were coming to both Werley and Lang, and Werley was not happy about that.
critiquing her comments and questioning each decision she made. While Werley was known for her no-nonsense editorial style, the constant barrage of unsolicited feedback certainly began to change Werley’s relationship with Lang, an accomplished and respected leader in her own right.

**NMDS Postconference**

On the heels of a tense summer between Lang and Werley, the postconference was held in Chicago in September of 1985. Each of the task force leaders revised and submitted reports summarizing their conference sessions, and the issues left unresolved created the agenda for the postconference meeting. The content and purpose of the clinical abstract, selection of a ND classification, and ownership of the data set were all on the meeting’s agenda. Each of the task force leaders and others in attendance at the

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conference had sent ahead comments to Werley, hoping to influence the remaining decisions to be made surrounding the NMDS.\textsuperscript{566}

The postconference meeting kicked off with a discussion about the general purpose of the NMDS. Werley stressed repeatedly that the data set was not designed to support clinical decision making; rather, it was set up to represent clinical practice after it was delivered.\textsuperscript{567} This clarification was needed because much of what the nurses involved with NMDS were focusing on was how clinicians might use the data set in practice as a decision-support tool. This focus was understandable; Werley and the other organizers had used the conference to discuss the development of nursing information systems designed to support clinical decision making. Again, this was a data set the group was trying to develop, a post-service use collection tool, not an active charting tool. Werley, adding to the mixed messages, had pushed for keeping many of the duplicate elements in the NMDS because in her view, it moved nurses closer to a universal model for documentation.

After refocusing the group, Werley moved on to a discussion about the clinical abstract. To date, the clinical abstract had been the catch-all for any data points that either did not fit into one of the NMDS categories or did not lend themselves to discreet consistent categories, for instance patient assessment data. The discussion of the clinical abstract brought concerns to the surface about the sheer size of the NMDS and the likely

\textsuperscript{566} See FN 610.
\textsuperscript{567} AM Proceedings of Postconference Task Force Meeting, 16 September 1985, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
poor acceptance of the information practice because of its size. It was suggested that the clinical abstract was actually a more appropriate and manageable representation of the nursing care delivered, and participants suggested that the clinical abstract should function as a face sheet to be completed at the end of a patient’s service use. Again, as with previous challenges, Werley tabled the discussion and moved to review the decision to place assessment into the abstract.

There were many concerns about the removal of assessment data from the NMDS. For starters, many of the postconference participants believed that leaving out these data would make it difficult to convey the clinical effectiveness of the interventions delivered to the patient. This was an argument made primarily by the academic nurses present at the meeting. The nurse administrators, on the other hand, argued for assessments exclusion, as they were worried about the large size of the NMDS and the inconsistency with which nurses applied assessment skills. Standardizing a particular level of assessment meant many of the nurses employed under the administrators would automatically fall short because of a lack of training. After much discussion, a vote was called, resulting in a 6–5 vote in favor of excluding assessment from the data set entirely, followed by unanimous support for inclusion of assessment data into the clinical abstract.569

The group next addressed the issue of ND. At the close of the conference, the remaining issue was how ND would be arranged within the NMDS, and two arguments.

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568 The data set at this point was a series of categories with definitions, followed by subcategories. Some of the subcategories had check lists, others had references to larger data sources. For example, the ND category referred users to the NANDA taxonomy, the Omaha system, or some other framework for ND.

569 Ibid.
were made: either organize ND by the sixteen assessment categories selected by the
NMDS group or choose one of several ND classifications in development. Those in favor
of using the sixteen categories associated with assessment argued for leaving the ND
category open, citing inconsistencies with application and general development of ND.
Moreover, if the section were left open, each facility could decide for itself which ND
classification best represented its practice area. Werley called a straw vote on the matter
in order to limit discussion and the results were as follows: 1 in favor of using NANDA’s
ND classification only, none in favor of NANDA and any other classification, 4 in favor
of NANDA and other recognized classifications, 4 in favor of the assessment framework,
and 2 abstentions.\textsuperscript{570}

The discussion moved on and the data category of nursing interventions was
reviewed. The group decided, with little protest, to remove interventions from the NMDS
and place them into the clinical abstract.\textsuperscript{571} Some expressed concern over duplicate
information contained in the demographic and acuity/intensity sections. After a brief
discussion, the information describing service elements was removed from the
demographic section. Although this move addressed the duplicate information within the
data set, the issue of the same elements contained in multiple data sets was not resolved.
Werley, taking a stubborn stance, refused to change the demographic information, nor
would she remove elements that were already collected in other sets, for example, the
Hospital Discharge Data Set.

\textsuperscript{570} Ibid.
\textsuperscript{571} PM Proceedings of Postconference Task Force Meeting, 10 October 1985, Norma
Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
The last and final issue taken up at the postconference was the issue of ownership of the NMDS. During the meeting sessions, group members voiced their concerns regarding licensing of the NMDS. Many felt that licensing would hinder the uptake of the NMDS by limiting interest to only those who could afford to purchase the rights. Overwhelmingly the postconference group felt it was most appropriate to allow for free use or public ownership of the data set. The group agreed that the University of Wisconsin-Milwaukee School of Nursing would house the data set, with Werley and Lang supporting its dissemination though various means.

Locating the NMDS with Werley and Lang was a logical decision. Many attendees during the course of the preconference, conference, and postconference had looked to both Werley and Lang for leadership. As mentioned earlier, Lang had recently completed chairing the committee that oversaw development of the ANA’s SPS and Werley was an established and respected member of the nursing community. Lang’s leadership style was one of consensus building and collaboration. Unfortunately, those same skills did not serve her well when working with Werley’s command and control style. The tension that had followed the two to the postconference meeting came to a head when Werley accused Lang of taking credit for the NMDS, irreparably damaging their relationship.


573 Note, September 1985, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
Werley’s accusation was odd, but not entirely unexpected. Communication about the data set to members of the profession was undertaken by both Lang and Werley, as were the inquiries about the conference. Lang, because of her strong connection to the ANA, was often a point of contact for many of the elected leadership of the organization. This began to upset Werley who felt threatened by the lack of control she had over the data set. However, it was odd because neither Werley nor Lang, nor any of the participants for that matter, could claim outright ownership of the NMDS. Realistically, all the elements described in the NMDS existed before and would continue to be used in various capacities after the NMDS was released for public use. Meetings such as the First National Conference for the Classification of Nursing Diagnosis occurred long before the 1977 conference and the NMDS conference that Werley arranged. In other words, these were simply not new ideas, and in that sense they defied ownership. However, it was not a surprising accusation, given Werley’s belief that this particular information practice was the key in identifying nursing’s role in patient care on both local and national scales.

Troubles with Dissemination of the NMDS 1986–1990

After the events in Chicago, Werley took to focusing on producing a manuscript of the conference proceedings. She found an editor interested in publishing the manuscript and continued to follow up with authors for their revisions. In addition to the manuscript, there were three planned dissemination strategies for the NMDS: raise awareness about the data set within the nursing community through various professional

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574 Springer had committed to publishing the conference proceedings. The proceedings were released in 1988.
conferences, solicit government agencies to adopt the data set, and begin applying for funding in order to conduct research on the data set.\textsuperscript{575}

The interaction between the general nursing community and the NMDS was minimal. Although Werley solicited feedback on the draft version of the data set from attendees of the conference and many of her professional connections, both groups of reviewers largely represented academic nurses, with some administrators and government officials.\textsuperscript{576} However, there was virtually no input from staff nurses, the group who would likely be using the NMDS the most. A few of the reviewers had misgivings about the selection of the NANDA classification, but almost all were concerned about repeating elements in the data set. Barbara Gallant, a nurse administrator, had attended one of Werley's presentations on the NMDS and had pressed Werley to address the information burden the data set placed on staff nurses.\textsuperscript{577} Gallant felt that staff nurses would bear the

\textsuperscript{575} AM Proceedings of Postconference Task Force Meeting, 16 September 1985, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee; PM Proceedings of Postconference Task Force Meeting, 10 October 1985, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.

\textsuperscript{576} There were few major comments received that were not reflected in the concerns of the conference attendees. For those who did respond they were asked to give feedback on the Proceedings of the Post-Conference Task Force Meeting on the NMDS, 16 September 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection. Lucille Joel to Harriet Werley, 30 October 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection; Carolyn Anderson-Stewart to Harriet H. Werley, 25 November 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection; Margaret D. Sovic, Professor of Nursing, University of Rochester to Harriet H. Werley, 11 November 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.

\textsuperscript{577} Werley described the interaction in a letter to Dean Lang. Harriet Werley to Norma Lang, 7 November 1988, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
brunt of the data collection required by the NMDS. Werley disregarded Gallant’s and others’ comments, leaving the duplicate elements intact.

That decision would prove to be a major hurdle as Werley turned her sights to gaining government acceptance of the data set. Werley’s work history was one of distinguished service to the armed forces. This service was well recognized, and her status within the nursing community was one of a certain level of reverence. She used her accomplishments and connections from her previous work to gain access to many leaders and organizations within the government. In particular, Werley worked closely with Faye Abdellah, Deputy Surgeon General and Chief Nurse Officer of the U.S. Public Health Service, to gain access to the U.S. Department of Health and Human Services. The department had created the Health Information Council to oversee the development of a variety of information practices aimed at evaluating health care services. Due to Abdellah’s assistance, the Health Information Council invited Werley and Lang to submit a letter outlining the benefits of the NMDS, including how this data set addressed the federal government’s information needs.

Per Abdellah’s instructions, the letter succinctly outlined the purpose of the NMDS and its potential benefit to the DHHS. Although Werley and Lang were cosigners on this letter, Lang offered only cursory edits because her relationship with Werley was close.

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578 The correspondence surrounding the NMDS submission was routed through Kathleen McCormick. The first citation here is a draft letter sent to Abdellah for review. The second is the feedback. Harriet Werley and Norma Lang to Dr. James O. Mason, Acting Assistant Secretary for Health, and Chairman Health Information Policy Council, 1 October 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection; Kathleen A. McCormick, Department of Health and Human Services to Harriet H. Werley, 11 November 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
remained strained. Werley’s first draft was disappointing, as it contained a litany of reason why the NMDS was important for nursing, but little about its usefulness to the government. Abdellah reviewed the letter and sent it back to Werley for revisions, stressing again the need to make the case for the data set in terms of its value to the government, not nursing. Werley made minimal changes to the letter and submitted it to the council for consideration.

The letter was submitted in August 1986 to the DHHS Assistant Secretary Robert Windom and routed to Ronald Blankenbaker, chairman of the National Committee on Vital and Health Statistics for review. At Windom’s request, the DHHS granted Werley a review meeting in October 1987 where the NMDS would be considered for adoption. However, instead of asking Lang to accompany her to the meeting, Werley invited her long-time colleague Elizabeth Devine. The two traveled to Washington, D.C. and presented the NMDS to the committee.

The committee commented primarily on ND, the profession-centric nature of the data set, and the duplicate data contained in the NMDS. The committee stressed that “considerable attention needed to be given to inconsistencies with nursing diagnosis” if the data point was to be used to capture costs. The committee was referring to the weak

579 Harriet Werley and Norma Lang to Dr. James O. Mason, Acting Assistant Secretary for Health, and Chairman Health Information Policy Council, 6 August 1986, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection; Ronald G. Blankenbaker, M.D. Chairman, National Committee of Vital and Health Statistics to E. Windom, M.D. Assistant Secretary for Health, 8 January 1987, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
580 Letter routed to Irma Lou Hirsch from Jan Heinrich, Letter from Ronald Blankenbaker, Chairman, National Committee on Vital and Health Statistics to Robert Windom, Assistant Secretary for Health, Department of Health and Human Services, 8
connection between ND and patient needs or resource use, a connection that was not measured by a single ND. If the relationship was explicated, the use of ND “might be particularly beneficial to current efforts to define severity of illness.” Additionally, the committee noted with concern that the proposed MDS was specific to services rendered by a particular profession rather than practice setting. Lastly, the committee commented that the DHHS would have to remove the duplicate data if they accepted the data set for use.

Months passed after the committee hearing and Werley kept in frequent contact with Abdellah, hoping for word. In April 1987, Werley received a letter from Assistant Secretary DHHS informing her that “no programmatic or administrative needs” were identified that would “warrant the promulgation within all programs for the department, the NMDS.” The data set did not meet DHHS’s information needs. Werley was understandably frustrated, as the phrase “no programmatic or administrative needs” was becoming an increasingly familiar refrain.

Werley had been communicating with Ron Norby, Chief Nursing Officer of the San Diego VA Hospital throughout the spring of 1987 in the hopes that the facility might

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581 Letter routed to Irma Lou Hirsch from Jan Heinrich, Letter from Ronald Blankenbaker, Chairman, National Committee on Vital and Health Statistics to Robert Windom, Assistant Secretary for Health, Department of Health and Human Services, 8 January 1987, Irma Lou Hirsch Papers, Private Collection, Author.

582 Ibid.

583 Ibid.
consider using the NMDS as part of its information system. Though Norby was interested in the data set as point of information, he had no intention of mandating the cumbersome, labor-intensive data set at his facility. Out of professional courtesy, he referred Werley to Vernice Ferguson, chief nursing officer for the VA system. Werley knew that the VA was in the middle of revising its nursing information system, launched three years earlier. Just as Norby had done, Ferguson entertained the idea of the NMDS, but in the end had no intention of adopting the data set.

Because of Werley’s professional connections, she was also given the opportunity in early February of 1989 to respond to the revisions proposed by the Joint Commission of the Accreditation of Hospitals (JCAH) to their nursing standards. Her recommendations included mandating computerized records in all facilities seeking JCAH approval. This was an impractical recommendation and was likely connected to Werley’s increasing belief that the reason she was having difficulty disseminating the NMDS was the lack of computer adoption by the health care industry, rather than the content of the data set.

While all these activities were occurring, Werley continued to seek funding for the NMDS project. She successfully obtained additional funding from the Healthcare

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584 Ronald B. Norby, Associate Chief of Staff for Associated Health Professions, Veterans Administration to Harriet H. Werley, 20 April 1987, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection. Ron Norby, personal communication, 24 June 2007.
585 Ron Norby, personal communication, 24 June 2007.
586 Harriet H. Werley to Vernice Ferguson, Director, VA Nursing Service, 2 July 1987, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
Corporation of America Foundation.\textsuperscript{588} The funding was to be used to support projects testing and refining the NMDS at two local Milwaukee acute care facilities, as well as several yet-to-be-identified dissemination projects. The moneys were a welcome relief for Werley, who had abysmal results obtaining other forms of support.\textsuperscript{589}

The support that the University of Wisconsin–Milwaukee had contributed, totaling over $85,000, was pulled shortly after the postconference.\textsuperscript{590} In a letter to Ursula Springer and Ruth Chasek, Werley outwardly blamed her school’s administration (indirectly accusing Lang) for her lack of productivity.\textsuperscript{591} Werley reflected, “I had a terrible time since June … I lost my secretary on June 30\textsuperscript{th}, then learned they will cut back the time to only a 50% slot, when the secretary could not keep up even at 100%. Then I discovered … that ‘they’ did not give a contract to a research assistant who is crucial to our ongoing research—testing and refinement of the NMDS.”\textsuperscript{592}

\textsuperscript{588} Harriet H. Werley to Ida Cooney, Vice President, Foundation Hospital Corporation of America, 1 July 1985, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.

\textsuperscript{589} The story surrounding Werley’s funding for the NMDS is commonly understood as coming primarily from the NIH. I did not find any evidence to support that. Werley had moneys from the Healthcare Corporation of America Foundation and the Blanke Foundation, a foundation that funds University of Wisconsin-Milwaukee faculty projects. The funds are usually similar in size to the Sigma Theta Tau Grants given out today. Werley did receive approval of her NIH application, but there was no evidence that the project was funded. Ada Sue Hinshaw, Director, National Center for Nursing Research to Harriet H. Werley, 29 September 1988, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.

\textsuperscript{590} Note, September 1985, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.

\textsuperscript{591} Springer was the Chief Executive Officer of Springer Publishing and Ruth Chasek was an editor. Harriet Werley to Ursula Springer and Ruth Chasek, 6 August 1986, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.

\textsuperscript{592} Ibid.
In addition to the waning financial support of the school, Werley was having increasing difficulty rallying support for the NMDS project from within the school. Lang had persevered with coediting of the conference proceedings, tolerating Werley’s relentless negative comments such as the following instructing Lang to “be precise and scholarly in your work so I do not need to check everything in such detail.” However, once the conference proceedings had been edited, Lang successfully avoided further involvement with the project, refusing, as she said, to feel “brow beaten.” The collaboration that seemed to have brought the NMDS project to fruition five years earlier was now absent and had been replaced by tolerant respect.

**Conclusion**

It is difficult even now to say whether the NMDS was a success or failure. It was, and remains to a certain extent, a failure when evaluated against the ambitious purposes outlined by the creators at the 1985 meeting. Yet those involved with the NMDS would likely argue that the project was successful; the preconference, conference, and postconference solidified new and existing relationships among nurses working on various elements of the data set. Perhaps a more appropriate question is how nurses involved with the NMDS selected information for inclusion and how this information practice shaped the work of nurses.

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593 Harriet Werley to Norma Lang, 23 June 1986, Harriet Werley Papers, unprocessed, University of Wisconsin-Milwaukee, Manuscript Collection.
594 Note, September 1985, Norma Lang Papers, unprocessed, Manuscript Collection, University of Wisconsin-Milwaukee.
595 At the conclusion of the postconference, the group had selected a series of categories, with accompanying definitions that they organized into the five original sections of the data set: demographic, diagnosis, intervention, outcome, and acuity. Later Werley would expand on these sections and categories to produce a booklet of a series of checklists.
Despite disputes over ownership, the NMDS is a shared information practice. The content of the data set was not original to Werley, Lang, or any of the numerous individuals who lent their time and talent to its creation. Rather, the elements were common political representations of nursing practice that were largely representative of the time. Nursing diagnosis signified the nurses’ outwardly claimed process of clinical reasoning and the subsequent expanding practice boundaries. The inclusion of the demographic section, where an individual nurse or group of nurses were identified, was important because it recognized nursing services that had previously gone unacknowledged. The notion of costing out nursing care in terms of acuity/intensity ratings was another popular representation of nursing practice that aimed to identify nursing services in billable terms.

When attempting to combine all these and the other items of the NMDS together, organizers had important political choices to make. On the one hand, they could mandate the elements of the data set and leave the particular data point open to customization by the facility; alternatively, they could mandate across the board both the element category and the specific data points. In most cases, choices were made that embedded either inflexible data points or standards into the data set, disregarding the larger nursing community’s investment in the information. The group opted for specificity, rather than general categories. These choices, coupled with Werley’s work and leadership style, made the prospect of adoption of the NMDS remote.

Adding to the difficulty was the overall political character of the information. Unlike the ND classification discussed in a previous chapter, the NMDS was a compilation of highly contested information practices. Factors such as the data set’s focus
on nursing rather than patients or a type of service, the inclusion of costing out nursing, and the outcome measurements that examined nursing’s influence on patients (however crude these early measures were), all made for a collection of politically charged data. This made shopping the NMDS around for funding, recognition, or other forms of uptake exceedingly difficult because it was rather easy to find an objectionable data point or category.

Many of the nurses were actively pursuing segments of the NMDS and developed metrics that measured different aspects of nurses’ work. Few continued to work on the NMDS itself, with the exception of Werley. However, the work of these nurses created no substantial waves with Werley because most of the participants were not directly involved with all aspects of the NMDS, with the exception of Lang. Perhaps no other event in this case is more illustrative of the political nature of information than when Werley accused her long-time friend and colleague of taking credit for the data set. Not only did Werley stake the latter part of her career on the NMDS, she also gave up personal relationships.
Epilogue

Clinical Information Systems and the Problem of Information Revisited

When the small group of nurses met to design the Nursing Minimum Data Set (NMDS), they, like hundreds of other nurses, were trying to understand and respond to new expectations being placed upon them by the public. The rapid changes in practice had caught many of these elite, highly educated women off guard and sent them scrambling to come up with the solution that defined the problems these changes brought. Those involved with the Classification of Nursing Diagnosis (CND), the American Nurses’ Association’s (ANA) Social Policy Statement (SPS), and the NMDS attempted to gain control over a seemingly out of control practice environment in which costs became the index of quality, and practicing nurses grappled with their newly acquired skills, tools, and knowledge. The nurses involved with the CND, the ANA SPS, and the NMDS looked on as nursing and the work of nurses changed before their very eyes.

Those who set out to find a solution to these changes in practice were sharply divided. Some proposed gathering new data, as they thought that nurses lacked information to make clinical decisions. Others believed nurses were buried under too much information, so they responded by creating new ways to organize existing data. The trouble with the approaches taken by the nurses in these cases, and other groups like them was their fundamental disregard of those individuals who were not only directly experiencing the changes, but who would, in the end, choose to adopt or reject the proposed information practice: nurses who worked directly with patients on a daily basis. No consideration was given to what type of information tool would best serve nurses working with patients. Instead, the nurses in each of these cases inadvertently focused on
what would best serve their own needs, both in education and research—and, if they were lucky, further their individual careers in the process.

The nurses associated with the CND, the ANA SPS, and the NMDS believed so fervently in the information systems they proposed and the work they were doing, that it sparked bitter and unfortunate divisions between long-time colleagues, among theorists and clinicians, and even between one organization and its members. Ultimately, what the cases illustrate is that these disagreements were less about the information itself and more about the belief in the power of information to shape practice. The irony is that the work of the nurses who designed the two information practices for use in clinical applications didn’t change the work of clinicians; instead, it changed the work of the nurses championing the NMDS and CND. Many launched research careers examining the very same information practices they proposed.

The distinction to be made here, and it is a fundamental difference between this and any other study examining clinical information systems (CIS), is that practice, not information, shaped the work of nurses. The social interaction between nurse and patient, and the broader ideas and expectations placed on nurses by patients, fueled the need for nurses to understand how best to respond. In the few historical overviews that examine the development of these systems, nurses involved with the creation of information practices such as the NMDS are often touted as raising up existing practice,596 in essence,

596 We can see other forms of this deterministic framework in what Davies calls “broad-brush” and congratulatory historical writings in nursing, see Celia Davies, *Rewriting Nursing History* (London: Croom Helm, 1980). These historical overviews often highlight the struggles of nurse leaders who fought to establish nursing, or in this case nursing-specific information practices. These writings reviewing the development of clinical information practices often cast nurse leaders in metaphorical language as
improving the care by changing the practice. I found this to be inaccurate and misleading, primarily because the nurses involved with creating the information practices were playing catch-up with what was actually occurring in practice. In many ways, they attempted to capitalize on existing changes occurring in practice, not create new ones. And by the time the nurses involved with these cases organized their task forces, practice had already moved on.

Another distinction between this study and other examinations of CIS is the general approach, or framework, used to analyze the systems. The present study recasts CIS as systems of skills, tools, and knowledge needed to provide patient care. Thus, the appropriate place for an information system is as a supporting, necessary tool used by clinicians during the course of providing care, a tool that is subject to the public’s expectations regarding nursing care and the associated skills and knowledge necessary for nurses to fulfill those expectations.

The cases presented here offer analysis of three different types of information practices: a classification, a definition of nursing, and a data set. The CND created the classification to address two challenges: how best to systematically identify the ways nurses used diagnosis, and how to administratively represent nurses’ work. The CND approached the former by attaching the word \textit{nursing} to \textit{diagnosis}. This forced serious issues to the surface, issues about practice boundaries and what was socially or

pioneers. This language of exceptionalism is of particular concern when examining the development of CIS, as it leaves out consideration of the role of the bedside nurse and patients, along with a plethora of other social factors. Examples of this type of writing can be found in: Pocklington and Guttman, \textit{Computer Technology in Nursing}; Hannah, Ball, and Edwards, \textit{Introduction to Nursing Informatics}; Ozbolt and Bakken, \textquoteleft\textquoteleft Patient-care Systems;\textquoteright\textquoteright Saba and McCormick, \textit{Essentials in Nursing Informatics}; Sackett and Erdley, \textquoteleft\textquoteleft The History of Healthcare Informatics;\textquoteright\textquoteright
commonly acceptable nurses' work. Although the public expected nurses to be competent, skilled, and knowledgeable about problems facing patients, claiming diagnosis as part of nursing practice put the CND's classification immediately at risk for those considering adoption for two reasons. First, not all nurses were overtly diagnosing patients, and second, those who were, did so with medical diagnoses, a more universal language. The classification tried to walk a middle ground between the two types of diagnosis, and in doing so made its potential for adoption slim because it would not appeal to either type of nurse nor did it use a common language understandable to all types of clinicians.

Another interesting aspect of the CND case is the way in which the various layers in the classification system, when combined, excluded most nurses. The first layer was the obtuse, often jargon-laden language selected to describe NDs. The language, coupled with the adoption of the word diagnosis, excluded many nurses whose practice was not reflected in the labels chosen. The second exclusionary layer was the selection of a nursing theory for organizing the identified NDs. In choosing Martha Rogers's Theory of Unitary Man, the CND group managed to alienate the very staff nurses they hoped would use the classification, thus prioritizing theory over practice, something that did not sit well with the clinicians working on the classification.

Although the cases examining the CND and the ANA SPS are different in many respects, the nurses working on these documents faced several similar challenges. Defining nursing has always been a risky political proposition because it inevitably entails attempting to unite the multitude of roles nurses play, the various educational options, and the profession's and public's beliefs about nurses and the work they do. Yet
the ANA was in a rather desperate place, having lost membership to growing specialization since the early 1970s. This loss caused a budgetary crises, and in response, the ANA asked its division of practice to pull together a document that would clarify nursing’s social contract in the hopes that it would become a unifying rallying point for its members and prevent continued membership losses.

In addition to the stated intent of the SPS, the ANA hoped the document would function as a Band-Aid of sorts aimed at convincing the nursing community that the ANA was still viable in terms of both its political clout and its standing within the nursing community. In projecting a definition of nursing that was contrary to the practice experience of many nurse practitioners (NPs) and an overreach to nurses still constrained by medical hegemony, the ANA ended up reinforcing the problems the organization faced and further alienating its membership. And while many describe the loss of membership primarily in terms of the advanced practice nurse, the more severe loss came later with the ANA’s separation from the California Nurses Association (CNA).

That split fractured the political clout and capital of the ANA in ways that we have yet to fully appreciate, and further illustrates how, in the attempt to define practice, the ANA simultaneously prioritized one nursing role while marginalizing another. It did so by focusing its attentions on the NP, rather than considering how specialization was affecting nurses in general.

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597 The California Nurses Association voted to separate from the ANA in 1989, with a formal separation occurring in 1990.
598 It also further hindered the ANA financially as the CNA was the second largest constituent group affiliated with ANA. Just prior to the split it was estimated that the CNA membership dues generated over $1.6 million in revenue. Report of Dues Revenue Received From State Nurses’ Association in 1987, 1987, Lorraine Freitas Papers, Private Collection, Author.
In revisiting the NMDS case, we see a small group of nurses who bring to light nearly every issue addressed in this dissertation. The choices the nurses made with regard to the data set content had much to do with their notions of what practice *should* be like, instead of what was actually occurring. And while reaching for the ideal as opposed to the reality is not in itself a negative thing, in their zeal to put nursing within the gaze of policy makers, they were unable to reconcile the tension between the two. They prioritized data based on their ideal operation of the existing system of care, and while they hoped to shape the work of bedside nurses, in the end, they set in motion initiatives that justified their own work. Furthermore, individuals involved with the data set had such a fierce belief in its power to effect change, that they were willing to jeopardize friendships and stake their careers on the NMDS.

The common thread that pulls these cases together is that each was an attempt by elite groups of nurses to define the changes occurring in practice and provide potential solutions in the form of tools or information practices. Each group held a belief in the power of information to shape practice, and designed their tools according to the nursing work each viewed as important. The nurses involved in the cases were removed from practice, and the exclusion of practicing nurses meant that the information tools themselves did not reflect current priorities of nurses' work. Their attempts were largely unsuccessful because they ignored the needs of those who delivered nursing care and would ultimately decide the success of their tools.

When we think about how the nurses involved with the three cases prioritized, organized, and promoted certain types of information, we can see how they valued certain aspects of nursing practice over others. An argument can be made that the nurses
involved with the various cases valued the portions of nurses work that were separate from medical practice. The CND wanted nurses to use nursing diagnosis (ND) not medical diagnoses, the SPS wanted nurses not to treat disease but a patient’s response to disease, and the NMDS wanted to create a record of a patient’s stay that only reflected the contribution of nurses. This need to separate nursing from medicine largely reflected the self-consciousness of the nurses involved in the three cases, many of whom came of age in nursing during a time when it was subjugated to medicine. The idea that nurses would willingly practice aspects of medicine, or actually want to, was not something these nurses envisioned for the profession and the information practices they designed reflected this.

Moreover, nurses involved with the CND, the ANA SPS, and the NMDS were some of the first nurses with advanced education, and as such they desired to develop nursing as an academic discipline. The tools each designed were meant to reflect what they felt composed much of the academic or professional aspects of nursing, something that did not involve application of skills or tools associated with a great majority of nursing care. In essence, the nurses involved with these cases promoted the knowledge work, and only the portions of that work that could be isolated as nursing specific.

This stance simply did not reflect the work of bedside nurses; rather, it reflected the work of the nurses involved with the CND, the ANA SPS, and the NMDS. It overlooked the comprehensive nature of the changes occurring in practice that demanded nurses be knowledgeable not only about patient conditions, but also about how to catch changes in conditions before they became too severe, and what to do about them—this was sophisticated knowledge work! One of the key issues at play in the dissemination of
information practices developed by the nurses in each of the cases was that, in a very real sense, the tools devalued this complex emerging role.

To address the larger historical question posed in this study—did CIS shape the work of nurses, and if so how—we need to revisit the definition of CIS. CIS are the skills, tools, and knowledge needed to provide patient care. As illustrated in chapter 1, CIS were changing primarily because patients' expectations of healthcare and nursing care were changing. As a result, nurses were taking up new skills, tools, and knowledge in order to meet patient needs. CIS influenced the work of the nurses involved with the CND, the ANA SPS, and the NMDS in the sense that each attempted to reshape the CIS through the insertion of a new tool. In essence, patient expectations shaped the work of bedside nurses, bedside nurses responded by changing their practice to meet those expectations, and the combination of the two prompted the work of the nurses involved with the CND, the ANA SPS, and the NMDS.

Next Steps
From the cases examined in this study, one can draw numerous conclusions related to current practice. Examining the varied ways in which these groups prioritized, organized, and promoted information practices provides us with vital insight into how to develop and disseminate future information practices. Perhaps the trend in these historical cases that can most inform present-day issues surrounding information is the makeup of individuals who developed the information practices. Time and time again, the composition of the group determined who would benefit most from the information practice and where the information practice would likely be applied.
Study of these historical cases also provides space to reconsider present-day enthusiasm surrounding CIS. The hopes that information can change nursing practice are no different now than they were nearly forty years ago, and often lead to calls for costly investments in technological infrastructure to support these changes. However, these systems and the supporting technology are more than a compilation of software, hardware, and networking capacities. As we have seen throughout the three cases presented here, information represents people’s beliefs about the nature of nursing care and its relation to other disciplines and to patients.

Lastly, when looking ahead to future studies examining CIS, four key areas warrant additional inquiry. The first is further investigation into the three cases presented here. During research for this study, I identified additional archival material that can provide further breadth and depth to the case surrounding the ANA SPS. It would also be instructive to extend the timeline associated with the ANA SPS to include a detailed account of the split between the ANA and the CNA, as well as the CNA’s successful passing of Assembly Bill 394, also known as the Safe Staffing Bill. This extension would provide for an opportunity to evaluate the bill, which can arguably be slated as an example of a successful use of the information practices surrounding acuity/intensity measures. In addition, the passing of the bill is illustrative of how nurses began to use patient safety as an issue and strategy to generate public support. More important, this

599 Most recently there was an article released in Nursing Economics that touted information technology as key to alleviating the growing shortage of nurses. See Ginny Meadows, “The Nursing Shortage: Can Information Technology Help?” Nursing Economics, Jan/Feb (2002): unpaginated on-line edition. Also see the entire issue of the September/October issue of Health Affairs. Health Affairs, 24, no. 5, September/October (2005).

600 California Assembly Bill 394, 1999.
extended study would provide the opportunity to understand the foundation of the bill's passing—a collaboration that brought together nursing's political interests and the public's demand and support for the bill.\textsuperscript{601}

The next portion of analysis needs to be conducted on a selection of comparison cases, preferably in medicine and government agencies, into how their information practices have been developed. One of the major influences on the work of the NMDS nurses was the development of the Professional Standards Review Organization's (PSRO) practice standards.\textsuperscript{602} Many sources detail not only the key information decisions made by the PSRO, but also how those decisions were influenced by contemporary conceptions of medical care. Additionally, sources involved with government agencies such as the Health Information Council of the Department of Health and Human Services are available and can provide an interesting alternative perspective to the three cases presented here.

Despite my attempts to ascertain a detailed story of the VA San Diego's development of information practices, more work is needed in this area. One challenge with accessing these institutions goes beyond overcoming the hurdles associated with the Health Information Privacy and Portability Act and the Institutional Review Board. A researcher needs to build a significant amount of trust with an organization's members in order to tap into its informal social network. This network not only holds a tremendous

\textsuperscript{601} The passing of the bill was after a ten-year effort by CNA in conjunction with various patient advocacy groups.

\textsuperscript{602} The PSRO was formed with the passing of the amendment to the Medicare/Medicaid legislation in 1972. The standards developed dictated elements of both nursing and medical practice and were subject to vociferous debate from established medical organizations, like the American Medical Association. The standards covered long-term care, ambulatory care, and acute care.
amount of information with regard to the institutional memory, but it can also identify potential sources that can be used to create a historical case. Plans are underway to continue this work with the VA San Diego Healthcare System and expand the organizational cases to include Mountain View Hospital located in Mountain View, California.

Conclusion

The changes that occurred in healthcare during the 1970s, '80s and '90s prompted significant shifts in the way nurses thought about patients. These changes demanded that nurses acquire new skills and apply new tools and knowledge to patient care. Although practicing nurses across the country applied these new skills, tools, and knowledge in varied ways, patients’ expectations were more uniform. Patients wanted their nurses to be skilled at detecting health problems, answer health related questions, and provide comfort when the patient fell ill. Most practicing nurses across the country responded to these expectations largely within the parameters of their particular situation. However, the elite groups in this study were caught off guard by the rapid pace and irregularity of the changes and responded by attempting to develop information practices that described, while simultaneously standardizing and controlling, the changes occurring in practice. Their attempts were unsuccessful because of their disregard of the end user and their failure to recognize the political nature of the proposed information practices.
Appendix A: Abbreviations

AACN. American Association of Colleges of Nursing
ACS. American Cancer Society
ADL. Activities of Daily Living
ADPIE. Assessment, diagnosis, plan, intervention, evaluation.
AHA. American Hospital Association
AMA. American Medical Association
AMRA. American Medical Records Association
ANA. American Nurses Association
APA. American Psychological Association
CIS. Clinical information systems
CNA. California Nurses Association
CND. Classification of Nursing Diagnosis
DHHS. Department of Health and Human Services
DRG. Diagnosis-related group
FOIA. Freedom of Information Act
HMO. Health maintenance organization
HRG. Health Research Group
IOM. Institute of Medicine
JCAH. Joint Commission for the Accreditation of Hospitals
LOS. Length of stay
MDS. Minimum Data Set
MIS. Management Information Systems
NANDA. North American Nursing Diagnosis Association

NAPNAP. National Association of Pediatric Nurse Associates and Practitioners

NCG. National Conference Group

ND. Nursing diagnosis

NLN. National League of Nursing

NMDS. Nursing Minimum Data Set

NP. Nurse Practitioner

POMR. Problem-oriented medical record

PSRO. Professional Standards Review Organization

RIMs. Relative intensity measures

SOAPE. Subjective, objective, assessment, plan, evaluation

SPS. Social Policy Statement

VA. Veterans Administration

VASDHS. Veterans Affairs San Diego Healthcare System
Archival Sources

A number of archival sources were used for this dissertation. Below is a list of the material used for this study and their status at the time of my visit.

Barbara Bates Center for the Study of the History of Nursing, School of Nursing, University of Pennsylvania, Philadelphia, PA. Dorothy Smith Collection, processed.


University of Wisconsin-Milwaukee, Manuscript Collection, Norma Lang Collection, unprocessed.

University of Wisconsin-Milwaukee, Manuscript Collection, Harriet Werley Collection, unprocessed.

VA San Diego Healthcare System, Organization Archives, Medical Library, unprocessed.

Burns Library, Rare Books and Special Collections, Boston College, Boston, MA. The North American Nursing Diagnosis Association Collection, unprocessed.

The Howard Gotlieb Archival Research Center, Boston University, Boston, MA. The American Nurses’ Association Collection, processed.

Articles, Books, Government Reports, Presentations, etc.


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