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The Injustice of “Just” A Nurse: How Perceptions and Stigmas of Gender Have Influenced Nursing and How Compassion-Based Care and The Goals Of The American End-Of-Life Movement Can Shape Medicine Moving Forward

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**The Injustice of “Just” A Nurse:
How Perceptions and Stigmas of Gender Have
Influenced Nursing and How Compassion-Based Care
and The Goals Of The American End-Of-Life Movement
Can Shape Medicine Moving Forward**

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Introduction: The Tale of The Modern Nurse

Nearly anyone who has ever faced a severe medical situation, or who has helped a love one through a severe illness, can attest to the importance of a skilled, compassionate, and competent nurse. Still though, nurses, continue to be erased and forgotten into the background of a patriarchal society that values the traditional male traits encouraged in the standard medical training of physicians, such as blind confidence, gusto, and a level of arrogance. As a result, the fundamental skills of modern nursing, including a compassionate and patient-centered approach to medical care, are often overlooked in assessing the quality of medical care. In many ways the mark of a good nurse for the majority of people is one that they can hardly remember, meaning kind, compassionate, and, most of all, out of the way. In many ways these are also the ways in which society views the traits of a “good” woman. It is impossible to ignore when looking at the development and perception of modern nursing the incredibly gendered history from which nursing as a field has come and the various positive and negative ways in which the images of women as naturally compassionate, kind, and caring, have shaped the ways in which American society views and treats nurses. This is particularly true when looking at the modern American End-of-Life Movement. It is also important to note when examining the gendered history of nursing that even within the field of nursing there has been exclusion of many women, particularly women who are not white, cis-gendered, and middle class with some level of access to education (Malka 7). Looking at the ways in which nurses have been viewed by society, treated by medicine, and portrayed by

the media, provides a fascinating insight into how American society views the work of women, particularly in the sciences, and how gendered work continues to dominate professional fields.

One of the reasons that nursing has struggled with confusion and misunderstanding around the work of nurses is due, in part, to the various etymological uses of the word nurse, ranging from the act of breastfeeding and wet nurses, to governesses, to various types of healthcare professionals. This language has reinforced the already present assumptions of nurses as female, but it has also created a level of confusion and misunderstanding around the actual work that various nurses do. To further this problem, nursing education has shifted and grown over the last 100 years, resulting in various titles for different types of nurses and various institutions in which nurses were once educated. While many Registered Nurses (RNs) were educated in hospital training schools until the late 20th century, many modern nurses, who still use the title of RN, now almost always have a Bachelor of Science in Nursing (BSN) degree, a four year college degree, or an Associate of Science in Nursing (ASN), a two to three year degree. On top of this there are also nurses with less formal training, namely Certified Nurses Aids (CNAs) and Licensed Practical (or Vocational) Nurses (LPNs or LVNs) who usually complete training or vocational programs. There are also nurses who hold advanced degrees, usually at least a Masters of Nursing Science (MSN) and often a doctoral degree, called Advanced Practice Registered Nurses (APRNs), also called Nurse Practitioners, who have more specialized training and have the knowledge to supervise care in many of the same ways a physician would. Many continue to see

nursing as a uniform and homogeneous profession comprised of people who must conduct the hands on personal care tasks of healthcare because they are not intelligent enough to be physicians or medical researchers, which were historically male positions (Maas 6).

Nursing also remains a misunderstood and stigmatized field due to the variety and difficulty in defining the tasks nurses do (Maas 11). Many members of the general public, due to media portrayals of various medical professionals and gendered perceptions of the “natural” inclinations of women, continue to see the work of nurses as unimportant when compared to that of doctors. As the ecofeminist scholar Carolyn Merchant discusses in her opposition to terms such as “Mother Nature,” within many societies there exists a natural inclination to associate and culturally link femininity and traditional images of womanhood with nature (Merchant, *Earthcare* xv, 42, 76, Merchant, *The Death of Nature* 1). This conversely links male traits with the mind, culture, and intellect (Merchant *Earthcare* 67). This trend can clearly be seen in various facets of society, but it is particularly prevalent when one examines the relationships society has with the established medical hierarchy and the relationships in how physicians and nurses are viewed. As Merchant discusses, much of the association between “Mother Nature” or Gaia and women is the idea that nature, similar to an overworked and underappreciated mother, is there to clean up after male created messes and to be unendingly forgiving and loving (Merchant, *Earthcare* xvi, 4-5). This assumption is also clearly made of many nurses, who are expected to be available at a moment’s notice and provide whatever service is deemed necessary of them, whether or not it

is part of their actual job description. This assumption results in a lack of respect, understanding, or kindness towards nurses (Brencick and Webster 139). The metaphor of women as nature, and the connections this draws between women and the body, can also be observed in the ways in which nurses are often portrayed in media as the “battleaxe.” (Summers and Summers 216). This dichotomy of the subservient handmaiden, another popular media depiction of nursing, and the cruel hearted sociopath further plays into the idea of women as nature, both in the kind, all forgiving mothering role, and in the role of the wild and unpredictably cruel bringer of disasters (Summers and Summers xii, Merchant, *The Death of Nature 2*). In this way women, and nurses as an extension, are seen as beings that need to be controlled and supervised by males, who historically have been viewed as solving the mysteries of nature through science (Merchant, *Earthcare* 59, 77). This depiction of nurses has led to the culture of requiring extensive, and unnecessary, supervision for advanced practice nurses. These highly educated professional nurses are almost universally seen, by members of society with little to no knowledge of the training that goes into becoming a nurse practitioner, as being a danger to society should they not be under the tight supervision of a, usually male, physician (Maas 7).

In many ways the stigmas, invalidation, and misunderstanding nurses face, both from within and from outside of the medical establishment, is a result of a lack of societal value placed on compassion and the close connections among compassion, women, and motherhood. There has long been tension, especially following the second-wave feminism movements of the late 20th century around the idea of women being seen as naturally compassionate and caring. In many ways the

early professional nursing movement started by Florence Nightingale was able to succeed because it created a professional field for women centered around what society saw women as being meant to do naturally, which was to take care of people. This profession allowed women to work outside of the home while still remaining in their societal place as mothers and wives, making nursing a “moral” profession (Newham 41). By being nurses, even unmarried Victorian women, could be seen as mothers and, as a result, successful at “being” women (Huppertz 67). For this reason nursing, being rooted in connotations of care and compassion, will always, in some ways, limit it within modern patriarchal society and hold the field back from receiving the full recognition and support it deserves. This standing in society does not mean that nursing should move away from a model of compassion and care. What makes nursing a unique and valuable addition to the practice of standardized and institutional medicine is that it is one of the few fields that actively works to incorporate and celebrate physical, spiritual, and emotional support for patients and their loved ones. Nursing, similar to ecology, practices science within the realm of holism, meaning that one looks at the whole system of a unit, as in the case of ecology nature. In the case of nursing, the unit is the patient and their family’s entire existence and being, and the objective is to create a better system of study and practice (Merchant, *Earthcare* 87-88, Stevensen 238).

In many ways nursing has struggled to be fully understood in society because there is a general lack of understanding between the differences in caring *about* someone versus caring *for* someone (Huppertz 68). This has led to the sexist assumption that if women are biologically inclined to be natural caretakers, then

working as a nurse is not work for them, but is instead a natural extension of their genetic drives and inclinations. Male doctors, on the other hand, have not evolved to care, and instead are practicing real, cold-hard science (Glass and Brand 41). This belief is not only clearly rooted in blatant stereotypes, but it also fails to acknowledge Florence Nightingale's conscious decision to base the field of professional nursing in compassion, and not cure-based values of medical practice. She intended to create a differentiation between the field of nursing and the field of medicine (Holt 2). It also speaks to the tension throughout nursing of the 20th century of recognizing and continuing to employ the compassion-based practices on which nursing was founded versus molding the field to fit closer within the medical establishment and cure-based medicine. This debate over how to conceptualize the roles of nursing has resulted in the continued presence of a lack of unity in the field, which has been true throughout its history (Risjord 35). The central issue that the debate over care-versus-cure-based medicine comes down to is whether there remains a place in the rapidly evolving world of technology supported medicine for care that is not centered around saving lives, but is instead focused on providing physical, emotional, and spiritual support to patients and their families. It is difficult to ignore the general societal resistance to these traits in the context of the highly gendered nature of medicine. While the male-based philosophies behind cure-based medicine aim to conquer illness and death and exert humans' power over nature, the female-based philosophies of care-based medicine aim to provide emotionally supportive care to patients and their loved ones and has a large focus in physical care. It is not surprising that in the American capitalistic healthcare system, not only

are patriarchal values of power, control, and domination over all things, including death, supported and advocated for, but these values are also seen as more important and requiring more skill and intelligence to properly execute than a care-based model, which takes a different, but just as valuable, type of skill and intellect (Wald 1684).

The field of nursing and its close associations with gender has also placed it within an interesting place within many feminist movements. Second-wave feminism in particular rejected many of the compassion and care-based aspects of central nursing philosophy (Malka 59). Particularly following the publication of *The Second Sex* by Simone de Beauvoir in 1949 and *The Feminine Mystique* by Betty Freidan in 1963, many women began to rightfully argue against the assumption that women were naturally caring and to increasingly push for women to have access to careers outside of this skill set (Merchant, *Earthcare* 9). As a result of these pressures, and increasing movements for women's liberation, women interested in science and medicine were no longer limited to careers in nursing. While this societal change in opening the fields of science and medicine to women was an achievement, it also further stigmatized the field of nursing in the public view. Some women's rights leaders were quick to distance themselves from nurses, who they viewed as weak and subservient, instead championing women who chose to enter into previously male dominated spaces (Glass and Brand 37). Women who now chose nursing were no longer seen as pioneers fighting to participate in a realm sexism had tried to prevent them from entering, but instead as less than female physicians. In the second half of the 20th century the stigma about nurses has

increasingly become that women who cannot, either because they are not smart enough, not driven enough, or not tough enough to become physicians, become nurses. This view is also, unfortunately, not unique to male physicians, with research showing the female physicians are quick to adapt to the same patriarchal views and stigmas around nursing once they have entered the position of patriarchal power (Gordon 42). This reinforcement of hospital hierarchies has only further created a dysfunctional medical system by teaching physicians that nurses are not to be respected or listened to and are not to be seen as instructors, even though hospital staffs often are comprised of far more experience nurses than physicians, who are often inexperienced and still in training (Gordon 30-31). This system of tension and lack of respect prevents teamwork from effectively forming within the medical staff of many hospitals and hurts patient care as a result (Gordon 40).

As nursing has advanced with the progress of feminism and society, many have also come to express their disappointment in the lack of self worth and lack of open pride many nurses have in their work (Maas 7, 10). This fact is likely due to the conditioning many women undergo from an early age that they must be humble and hold little value in themselves or their work (Bush and Kjervik 46). This idea is especially reinforced where nurses are expected not to correct physicians and are punished both by their supervisors and by society when they are seen as too assertive or bossy in their correction of a male (or metaphorical male) for making a mistake (Bush and Kjervik 55). Another side effect of this culture of ensuring that nurses stay within their social place beneath their historically male physician

colleagues is the lack of political power this place gives nurses. Though nurses far out number physicians in the hospital setting, they are kept within their subservient place through various social measures intended to constantly remind them that, as “good” women, they are not suppose to undermine men or appear to know too much, lest they be called a variety of sexist insults (Bush and Kjervik 46, Summers and Summers 7, Maas 7).

This observation is not to imply that nurses are weak or incapable of fighting back against the societal oppression they have long faced, both from within medicine and from society as a whole (Glass and Brand 33). A number of nursing leaders have created a culture of strong and ambitious women within nursing, starting with Florence Nightingale and her revolutionary act of creating one of the first, and only, professional fields for women. This culture of embracing strong and intelligent females has continued throughout nursing’s history as can be seen in the 1977 incident where Lucie Young Kelly, a prominent nursing professor at the time, brashly and publically called out a group of male physicians after a survey revealed the traits they most valued in a nurse included service to others, self-discipline, integrity, character, and good manners (Malka 63). Nursing leaders, like many strong willed and savvy women before them, have had to push carefully but forcefully in order to ensure the field was allowed to continue to exist while also fighting to maintain the integrity of their work as compassion-based healthcare providers. Particularly it is thanks to the monumental work of three driven, committed, and caring nursing leaders, Florence Nightingale, Virginia Henderson, and Florence Wald, that nursing exists in its modern form today. It is thanks to their

monumental contributions to the field, from Nightingale's professionalization of the field in the mid-1800s, to Henderson's defining of nursing in the mid-1900s, to Wald's development of the modern American hospice and palliative care movement in the late 1900s, that nursing not only continues to exist, but continues to make meaningful contributions to patients' lives.

Despite the setbacks that the close associations between gender and nursing have caused for the field, it is thanks to the gendered history of nursing that it exists in the remarkably powerful ways in which it does today. Particularly by observing the work of the modern American End-of-Life Movement, one can begin to fully appreciate the crucial importance of patient choice and compassion-based care, both traits that directly evolved from nursing's history as an almost exclusively female field, in modern medical care. Nurses have fought for the entirety of their 150-year history to ensure that the human aspect of medicine is not erased from the increasing corporatization and institutionalization of medicine as medical technologies are evolved and developed. As medicine and nursing continue to develop, it will become increasingly crucial that the care based aspects of nursing are not lost in favor of increasing pushes to standardize medical care, increase productivity and conform to capitalistic ideals. In many ways it will be the philosophies of nursing that will help to prevent this from happening. This outcome can only occur, however, if nurses, particularly advanced practice nurses, are finally given the respect, autonomy, and authority in the medical world that they deserve. The growth of hospice and palliative care in the last 40 years since their development in America has been incredibly promising, but research still shows

that many patients do not access these services until it is too late (Remington and Wakim 18). Moving forward in medicine, it will become increasingly important, particularly as end-of-life care grows as a field, for the medical establishment to no longer ignore the ideas and insights of nurses as it has for the past 150 years and starts listening and respecting nurses' expertise in this area.

Florence Nightingale: Creating a Professional Field For Women From Victorian Ideals of Womanhood

"It is often thought that medicine is the curative process. It is no such thing; medicine is the surgery of functions, as surgery proper is that of limbs and organs.

Neither can do anything but remove obstructions; neither can cure; nature alone cures. Surgery removes the bullet out of the limb, which is an obstruction to cure, but nature heals the wound. So it is with medicine; the function of an organ becomes obstructed; medicine, so far as we know, assists nature to remove the obstruction, but does nothing more. And what nursing has to do in either case is to put the patient in the best condition for nature to act upon him."

-Florence Nightingale

It is impossible to ignore the close similarities in the ways nurses are viewed in society and the history of nursing's development, starting with the work of Florence Nightingale, as the result of arising out of an almost exclusively female field. Similarly it is difficult to analyze the depictions and perceived roles of modern nurses without closely examining the effects that early 19th century influences in the professionalization of the field have had on the ultimate perceptions of modern day nurses. In many ways it was the key work of women such as Florence Nightingale in the early 1800s that allowed nursing, and the women who practiced in the field, to be seen as legitimate professionals. This early work, which was forced to incorporate various gendered stereotypes to allow the field to be accepted and to succeed, has also led to many of the biases against nurses that today hold the field back from receiving the respect, acknowledgment, and appreciation it deserves. In many ways, though the founding images of professionalized nursing have come to plague the field today. The revolutionary spirit that Florence Nightingale used to professionalize the field and create clear standards and methods of practice have

continued into the modern day, yet nurses continue to exist in a medical culture dominated by patriarchal values.

Florence Nightingale was born in 1820 in Florence, Italy to wealthy English parents (McDonald 1). She was raised primarily in England, the beneficiary of a luxurious and comfortable lifestyle as a result of her parents' wealth. Though extensive education for women was still not the norm for many women in mid-19th century Europe, Nightingale and her sisters received an extensive education supervised by their father (McDonald 5). At the age of 16 Nightingale received a "call to service" and informed her parents she intended to become a nurse, a profession for the poor and uneducated at the time that was seen as improper for a woman of Nightingale's social status (McDonald 1). In 1854, Nightingale was sent with one of the first teams of British nurses to care for injured soldiers in the Crimean War (McDonald 1). Following her return from the war in August of 1856, Nightingale who had been horrified by the inadequate preparations of resources she and her fellow nurses had been provided with, set out to reform and professionalize the field of nursing to prevent the high death rates she had observed during the war (McDonald 2). Nightingale used her education and social background to implement various trends, procedures, and cultures into the field of nursing, shifting it from one of highly subpar care, to one of the most organized, professional, and sanitary fields of medicine at the time. In the process she also established one of the first professional fields staffed almost entirely by women.

When Florence Nightingale suggested the professionalization of nursing in the early 19th century into a female-centered profession, this idea alone was radical

(Nelson and Rafferty 4). Prior to this point nurses had worked primarily independently, usually as low status workers under the vague supervision of a man of some type, usually a priest or other local person willing to take them on (Nelson and Rafferty 4). Early nurses were usually of a very low social class and seen as dirty and drunks (Malka 1). Prior to Nightingale's suggestion that this work be formalized, nursing was usually performed on an independent basis on a model similar to that of the modern babysitter where women would begin taking care of injured family members and neighbors, eventually hiring out their services through the local community by word-of-mouth (Lynaugh 77). Nightingale's work to change this process and remove the social stigma around nursing required her to make very conscious and clear efforts to remove the stereotypes about early nurses, changing the public image of nursing as for the dirty, destitute, and not "proper" woman. In the process of professionalizing the field of nursing, Nightingale established a clear public image of the professional nurse based around the idea of virtue (Nelson and Rafferty 1). Nightingale also worked to move nursing away from religious or domestic work and into the secular field, setting up nursing in the modern scientific framework observed today (Nelson and Rafferty 5). The work of Nightingale and her vision of nursing as a field rooted in traditional Victorian values, has in many ways led to the modern culture of nursing centered around listening to patients' needs. The work of Nightingale is often critiqued for creating a culture that encouraged women to be demure and subservient. However, in many ways this culture, and the more advanced views that evolved from a habit of listening, observing, and assessing, has prevented the modern problem of a condescending

top-down approach most other branches of medicine have increasingly made the norm.

In many ways nurses of the late 19th and early 20th centuries had no choice but to conform to the views of ideal womanhood pushed upon them by society to have any chance of succeeding in the male dominated fields of science and medicine that had been closed off to women in every other way. It was from this forced conformity by early nurses to an image of women who were unfailingly devoted, that today many people still immediately associate the letters RN with a caring, gentle female (Ward xv). Though the work of Florence Nightingale may not seem revolutionary or progressive by modern standards of gender equality, when one examines the times in which she was working, simply the idea of creating a field where women were able to, to a degree, dictate their own lives, is revolutionary. More importantly Nightingale served as a role model of not only leadership for women, but was an early inspiration for the idea of leadership as a central value of advanced practice nursing. For this reason the Yale School of Nursing, the first American graduate school for nursing, has kept a brick from Florence Nightingale's home as a tie to the roots of powerful, intelligent, determined women in the field of nursing (Nelson 20).

Much of Nightingale's legacy lies not only in the tangible changes she made to nursing, but in the culture she created around nursing, particularly around the ideas of community she infused into the central philosophies of nursing (Nelson 20). Her work also allowed women to take an active part in the hospital reform movement that followed shortly after her work to professionalize the roles of nurses, which

introduced sanitary and orderly practices to create the modern institutionalized hospital setting (Nelson 14). While this reform work was a small sphere in which nurses were able to execute political power, it was also one of the few opportunities for women prior to the 20th century to execute any type of suffrage or political power. Though Nightingale would likely be surprised by many of the more radical and revolutionary traits of the modern nurse, it is her direct legacy that has allowed nursing to evolve into a field filled with practitioners committed to patient-centered care and compassionate medical practice.

There is no denying that Florence Nightingale's work around nursing, and the greater implications this had for women, was revolutionary. However, it is also important to examine the role she played in drawing the close ties between Victorian ideals of virtue and womanhood and nursing and how that worked to create the stigmas and stereotypes around modern nursing. In Nightingale's quest to clearly establish a connection between "proper women" and nursing, she also accidentally set into motion the forces that have kept nursing resolutely gendered to the modern day (Nelson and Rafferty 6). Though Nightingale had little choice, by setting a standard of the ideal nurse as possessing the qualities associated with a "proper" woman, Nightingale set a clear public image grounded in concepts of femininity, propriety, and chastity that has plagued the field of nursing for the course of its history. Nightingale's "nursing ideals" also clearly rooted the field of nursing in a very white, proper, and British ideal, that ultimately greatly limited the field and made the career of nursing exclusionary to many people (Nelson 24).

In many ways Nightingale's efforts were a reasonable response based on the time in which she was functioning. But her legacy also left deep-rooted problematic views of nursing practices, which have prevented the field from developing as one might expect. For example, one early critique to allowing an almost exclusively corps of female nurses in the 19th century was concern over how young women could care for ill men and not risk their purity and chastity. In response to this Nightingale and her contemporaries framed the image of the early nurse as innocent and demure, the type of women who would not have impure thoughts (Nelson 22). This opinion of early nurses also directly led to the idea that nurses must be supervised, usually by older men, who would ensure they kept their place in society and that they remained "well-behaved" and obedient women (Nelson 22). In many ways this argument still overshadows much the debate around autonomy for Advance Practice Registered Nurses (APRNs). Repeated studies have shown that APRNs are qualified to practice independently, that allowing APRNs to practice independently would greatly improve both inpatient and outpatient care, and the current legal proposals would allow for independent practice of APRNs only after a set number of years of supervised practice. Nonetheless, the argument continues to be made, primarily by male physicians, that APRNs are inherently unqualified and need careful supervision, usually from a male physician. Imbedded in this argument is the sexist notion that a woman will never be as qualified, or even qualified at all, to do the work of a man, and the idea that though women may advance in society, they will always need to remain underneath men and remain supervised by their male colleagues lest they become too independent and uncontrollable.

Inherent in Nightingale's perceptions of the ideal nurse are the qualities of the ideal Victorian woman. From Nightingale's philosophies of nursing has come most of the modern basis of nursing philosophy and practice, and as a result, studies have found that even in areas where the gender divide in nursing is less than in the United States or Great Britain, there still remains a characterization of nursing as feminized and subordinate (Nelson 22). Central to Nightingale's vision for the future of the professionalized nurse was the idea that nurses were meant to serve humanity, as can be seen through the still very popularly recited, "Nightingale's Pledge" (Nelson 21). While the goal of serving humanity is a noble and honorable pursuit, and while this is still very much the goal of the unique work that nurses do, there is also a strong tie back to the ideals of motherhood and "proper womanhood." This idea invokes, in popular society at least, and clearly ties the field to womanhood. One must question whether it is inherent in a sexist society that the idea of serving and caring for others is inherently associated with women and if the field of nursing can ever exist in a way that is not distinctly gendered while maintaining these values.

Florence Nightingale's innovations and ideals of nursing also must be examined in a modern perspective for the illusion of power and female influence they gave, and continue to give. In many ways it is true that Nightingale's work on hospital reform, and the power and influence this gave female nurses in this specific sphere was revolutionary at the time. It is also important to acknowledge, however, that while women may have had some say in this reform, in the overall political oppression of many groups at this time, women's influence in hospitals was mainly

constructed on false influence. There is no denying that women were allowed to voice their opinions, as long as their opinions supported those of the men who oversaw them. This is similar to the common modern day phenomenon of the “falsely appreciated” nurse. It is not uncommon to hear doctors or other medical professionals profess the importance of nurses, particularly in regards to the idea of nurses “saving” ignorant residents from making careless mistakes. These comments are indicative of little genuine appreciation, as often subsumed in these comments is the assumption that one would firstly be surprised that a nurse would be more competent than someone who attended medical school (even if said doctor is in their early twenties and has only been practicing medicine for at most a few years) and secondly that this is a unique situation that will pass once the doctor has aged and gained wisdom. This phenomenon similarly creates a false sense of political power and influence in a situation where patriarchal values and assumptions have once again created a clear hierarchy modeled on traditionally male values and traits.

In the late 20th century, as nursing had clearly established itself from a field filled by young women, usually educated at a hospital-run nursing school, to one increasingly employing young women with college or masters degrees in nursing, an interesting shift began to take place. Increasingly the image of nurses began to shift away from the one established by Florence Nightingale of “angels in white” and instead began to become one focused around ideas of science. This shift in many ways seemed to legitimize the field more and began the first serious attempts to allow nurses more autonomy (Malka 2). In many ways the pushes of second-wave feminism and a resistance to the idea of women as solely caretakers helped to

greatly improve the treatment of nurses and change the public perception that nursing was unimportant women's work. In many ways the open public idea of nurses as women nourishing their mothering instinct until they were able to leave the work sector and devote their lives to raising children of their own began to be replaced by more subtle forms of sexism. As more opportunities in science and medicine began to emerge for women in the mid-1980s, the public perception of nurses evolved to become one that women who were too nurturing, soft, or not intelligent enough, became nurses, while those who were cut out to "compete with the boys" would go to medical school. In this shift of public perception and climate, much of the unique philosophy and reasoning behind the work of nurses was lost in the public's ignorance (Malka 2). Many of the productive pushes of second-wave feminism and the idea that women could do any job men could do, also suddenly invalidated in the public eye the legitimacy of jobs women had previously held almost exclusively, shifting the stigma against nursing in a new, but continuously gendered way. In a world where women could hold any job they wanted, why would any intelligent and ambitious women settle for caring for complete strangers? Second-wave feminists also objected to and sought to throw off the norms established by Florence Nightingale as the traditional values of an ideal woman (Malka 3).

With the social mobility of women in the medical world that occurred in the late 20th century, questions also began to subtly arise of how gender roles would continue to be maintained as the numbers of female doctors and male nurses increased, leading to the subconscious fear of what would happen if a male nurse

was now taking orders from a female doctor (Malka 4). To combat these fears the public created a specific image of the “male nurse” as not a “real” man; this idea was parodied in numerous forms of pop culture. Female doctors were portrayed as women who had made the type of “patriarchal bargain” described by historical scholar Judith Bennett, which allowed them to become “honorary men.” Both images permitted the patriarchy to remain intact (Bennett 59).

In many ways the continued existence of nursing as a field is a revolutionary act. Nursing remains one of the few fields that has been, and continues to be, shaped almost exclusively by women. Many top schools of nursing have never had a male dean, and concurrently, many deans of nursing schools were the only female deans in the history of their universities. Too often, as is usually the case with female-centered fields and institutions, people want to focus the topic of the conversation away from a proud female history, and instead focus on how many men can be brought into traditionally female spaces, as if having more male nurses will increase the validity of the pursuit. It is crucial in this period where nursing as a field is rapidly changing to be aware of these tropes and carefully resist the pressure to write off the gendered history of nursing, and the work of women such as Florence Nightingale, in an effort to conform nursing to the traditional patriarchal model of medicine. Many of the central ideals of nursing philosophy, mainly the focus on compassion that would later drive the nursing-centered American hospice movement, come directly from the values of an ideal Victorian woman that guided Florence Nightingale’s vision for professionalized nursing. Instead of trying to ignore the gendered history from which nursing has come, medical institutions, and

the general public perception, must shift to acknowledge, encourage, and celebrate nursing as a legitimate and unique approach to medical care.

Virginia Henderson: The Fundamental Role of Compassion In Nursing

“Nursing is primarily helping people (sick or well) in the performance of those activities contributing to health, or its recovery (or to a peaceful death) that they would perform unaided if they had the necessary strength, will, or knowledge. It is likewise the unique contribution of nursing to help people to be independent of such assistance as soon as possible...The nurse is temporarily the consciousness of the unconscious, the love of life of the suicidal, the leg of the amputee, the eyes of the newly blind, a means of locomotion for the newborn, knowledge and confidence for the young mother, a voice for those too weak to speak, and so on.”

-Virginia Henderson

Through her revolutionary work and vision around the potential held in the field of nursing, Florence Nightingale created the basic structure to allow for the tremendous growth of nursing as a professional field and created a professional opportunity for women outside of the home. Nightingale centered nursing within the hospital, allowing the field to gain respect and an established place in medicine as life expectancies increased with the development of better medical technologies and procedures. Inherent in rooting her vision for nursing in the hospital was the resulting hierarchical structure that quickly developed, placing nurses as a level lower than that of other medical professionals and creating a medical system that devalued and misunderstood the role of nurses. While this allowed for nursing to gain an established place in medicine, it also ensured that nursing would never receive the full respect of other medical professions. For most of the early 1900s the idea of questioning the roles of nurses and the under appreciation they faced was not considered, as the general societal view persisted that women were natural caretakers and they were to be seen and not heard. As early movements around feminism began and the work of women slowly came into the public discussion, so

too did conversations, both inside and outside of medicine, around the roles of nurses and the unique value in their often unnoticed work. From this discussion came a push to provide a definition for the work of nurses. This desire for clarity would be answered by Virginia Henderson, a nurse theorist and practitioner, who provided one of the first functional definitions of nursing in 1955. In her definition she wrote that the central role of the nurse was to assist a patient and their family when they could not help themselves, with the goal of either returning them to independence as quickly as possible or to achieve a peaceful death (Henderson, "The Concept of Nursing" 25). Henderson was one of the first people not only to offer a clear definition of the work encompassed by nursing, but she also consciously wrote her definition without medical jargon and in a manner that would be free to evolve with time, recognizing the importance of clarity, accessibility, and flexibility in medicine (Arnstein xi). The creation of Henderson's definition marked a monumental moment in the quickly evolving field of nursing theory as it was one of the first times the unique roles of nurses and the value in compassion based medicine was clearly articulated on a large scale. As such, Henderson's definition continues to be used in the educating of many modern nurses.

Virginia Avenel Henderson was born in Kansas City, Missouri in 1897, less than 50 years after Florence Nightingale had established the field of modern nursing (Arnstein xiii). Similarly to Nightingale she was not afraid to fight for what was right and quickly established herself as a leader and pioneer in the growing world of nursing theory and research. Henderson never intended to go into nursing, but, similar to many other women at the time, she was drawn into nursing by World War

I. While in nursing school she fell under the mentorship of Annie Warburton Goodrich, an incredibly influential nursing leader of the early 20th century who would go on to become the first dean of the Yale School Nursing, one of the most influential producers of nursing theorists (Arnstein xiv-xv). Though Henderson was more interested in working as a practitioner, she was quickly recruited into the world of nursing education, taking a teaching position at the Norfolk Protestant Hospital in Virginia (Henderson, *Contemporary American Leaders In Nursing* 117). A short while later Henderson enrolled in Columbia's Teacher's College for nursing education, completing her B.S. in 1932 and her M.A. in 1934. In many ways this decision to enroll in advanced schooling for nursing is a reflection of the increasing trend as nursing evolved away from the vocational field Florence Nightingale had initially imagined, and into a period of nursing education heavily based in research and academic theory. After receiving her advanced degrees from Columbia, Henderson returned to teaching, particularly making her mark at the Yale School of Nursing. Henderson was unique in her teaching at the time for the strong emphasis she placed on science and research in her education of nursing students, which also helped to move nursing into the traditional academic discipline and away from its more practical roots (Arnstein xiv). In many ways Henderson was able to take part in the rapidly changing society she was a part of around women's rights, pushing for recognition and respect for nurses that someone of Florence Nightingale's period never would have imagined possible. Not willing to stand idle and allow medical care to suffer because of a refusal to acknowledge the unique roles nurses play in patient care, Henderson set about formulizing definitions of the inherent nature of

nursing, understanding the power that can come from a clarity of purpose. She also worked to educate her students in a way that would allow them to not only be effective, caring, and efficient nurses, but also would empower them to fight for their own rights within medicine. This advocacy by Henderson led to the creation of the modern subculture within nursing of valuing compassion-based medicine and working to educate the general public on the need for both care-based and cure-based medical practices (McBride ix).

Much of the reason Virginia Henderson was able to take the drastic and revolutionary positions around the advancement and fundamental purpose of nursing was because at the time she was working as nurse. This time period recognized research and other scholarly pursuits not only for their inherent value to the field of nursing, but also to recognize and encourage nursing leaders (Lazenby E10). This open culture of change and freedom of growth for the field was something Florence Nightingale never had available to her in the rigid Victorian structure in which she was functioning. The period in which Henderson was producing her most influential work, from the early 1950s until the late 1970s, was perhaps one of the largest periods of change in the field of nursing as countless nursing leaders rose to prominence. Of particular importance in creating a culture of nursing that allowed for Virginia Henderson to postulate many of her theories of nursing was the articulation of the “nursing process” by nurse Ida Jean Orlando in the 1960s (Henderson, “The Concept of Nursing” 24). This event in nursing history helped to lead to the culture of nursing that allowed Henderson’s work to receive widespread interest as the field of nursing was increasingly encouraged to take an

introspective approach in examining its own processes, values, and procedures.

Virginia Henderson was practicing nursing and nursing theory in a period of great change and growth for the field of nursing. As a result, she was able to put into place many of the highly influential and revolutionary structures and ideas of nursing philosophy that would set the stage for the many revolutionary nursing acts that would follow in the second half of the 20th century. Among the most important was the building of the foundation of the American End-of-Life movement in the late 20th century.

As Virginia Henderson rose to prominence in the world of nursing education in the mid-20th century she quickly distinguished herself as a leader in the field of nursing. Similarly to Florence Nightingale's leadership around professionalizing the field less than a century before, Henderson immediately began to notice a number of areas of the field of professional nursing that were lacking in clear definition and development and set out to rectify this problem. Primarily Henderson took note of the need for a clear definition for the unique purposes and goals of the field of nursing, especially in distinguishing nursing as equal but distinct from other forms of medical practice (Arnstein xv). Henderson was also highly motivated to provide a clear definition of nursing following her observations around the great misconceptions regarding the philosophy and meaning placed on the practice of nursing (Pokorny 57).

As Henderson became involved not only in the practice of clinical nursing, but also in the teaching of nursing, she came to find that it was difficult to tangibly measure the work of nurses since much of their work was centered around care and

compassion-based tasks (Henderson, "Excellence in Nursing" 77). This resulted in an undervaluing and misunderstanding of the work that nurses were doing that has continued to plague the field into the modern day. This inability to clearly categorize and measure success within nursing by traditional means also led to confusion over what nurses were doing and what nurses should be doing (Henderson, "The Concept of Nursing" 21). Much of this confusion Henderson observed as an early practitioner and educator of nursing led her to further investigate the links that were caused by people not having a clear understanding of the actual work nurses did and the stigmas around nursing that arose as a result. She was also inspired by the nursing philosophy of her mentor, Annie Warburton Goodrich, around her concept of the development of a nurse being broken down into the three stages of sequential development: emotional, technical, and creative (Henderson, "Excellence in Nursing" 77). Goodrich's philosophy around the growth process of a nurse speaks to the growing trend in the early 1900s that not only consider the process by which one becomes a "good nurse," and what constitutes a "good nurse," but also the idea that there are deeper levels to nursing than just the technical aspects of the role.

Much of Henderson's research into the public perception of nursing found that the general public often views nurses in the role of "professional mother" (Henderson, "The Concept of Nursing" 24). Due to the etymology connections between the term "nurse" being used to signify everything from a health professional, to a child's caretaker, to the act of breast feeding a child, Henderson hypothesized that it would be difficult in many ways for the general public to separate colloquially the ideas of nursing as a profession from images of physical

care and womanhood (Henderson, "The Concept of Nursing" 22). Henderson took her argument around the connections between the linguistic links of feminine caring and the professional field of nursing further, arguing that nursing need not distance itself entirely from its roots in physical care; instead society needed to be made aware of the need for compassionate medical care. In this way Henderson was one the first nursing theorists to explicitly label the purpose of nursing being rooted in physical, emotional, and spiritual patient care. This distinction would later lead up to the most fundamental divide between nursing and other fields of medical practice in the idea of care-based versus cure-based forms of medicine.

When Virginia Henderson wrote in 1955 of shaping both the modern and future models of nursing around the activities of living, she was putting into clear terms what nurses had always known their work to be. She was also laying the groundwork to shape the future of nursing in meaningful and clear-cut ways (Nicely and DeLario 72). Henderson was not the first person to have these thoughts or conceptions of nursing. Nurses from the beginning of the profession had been recognizing, both formally and informally, the value and role of patient-centered caring-based practices of medicine. Yet Henderson was the first person to widely articulate these central philosophies of nursing theory and to create a clear set of goals and focuses for the nursing profession. She was also responsible for clearly articulating that nurses are not just "women who were not smart enough to be doctors," but must be inherently good people to be good nurses and that nursing candidates must have a number of predisposed characteristics, including intelligence and social awareness, in order to succeed in the field (Henderson,

“Excellence in Nursing” 77). Henderson’s philosophy of nursing specifically laid out 14 basic needs that she argued all people have, starting with simple life sustaining tasks, such as breathing, eating, drinking, and sleeping, and moving into deeper personal needs, such as the need for religious practice and meaning, the need to be clean, the need to express oneself, and the need to be without the threat of violence (Henderson, *Basic Principles of Nursing Care* 42-43) Much of Virginia Henderson’s research and advocacy around nursing and the defining of nurses’ roles focused on the need for humanity, kindness, and compassion in medical care. She was an advocate for the concept that the best practice of healthcare is not just patient focused, but also family focused, and stressed that a patient’s physical and mental health cannot be separated (Nicely and DeLario 72 and Henderson, *Basic Principles of Nursing Care* 17). This recognition of the patient as a human that is far more than just their medical history is a perspective that is still heavily lacking, especially as modern medicine becomes increasingly technology based. The patient as a whole is divorced from many forms of medical practice, but this concept has been central to the development of nursing theory and practice. Henderson also advocated heavily that nurses needed to get within the “skin” of their patients to better understand the experience they were having (Lazenby E10). In this way she was referring both to nurses thinking more critically and compassionately about the effects of the illnesses affecting their patients and the treatments they were providing. She also meant for nurses to look at the lives of their patients on a larger scale. Henderson encouraged nurses to examine factors such as socioeconomic status, family structure, and various cultural influences. She urged nurse practitioners to provide

treatments that would be best suited to an individual patient's needs and not based on the nurse's personal opinions or the model of an ideal textbook patient. In this way patients were given options and solutions for treating their medical ailments that were better suited to meet their specific needs. Patients were more likely to accept treatment that was meaningful to the patient and their family and treatment was more likely to be seen as successful for the individuals involved. A large part of Virginia Henderson's philosophies around nursing also centered on the idea that while the nurse must work to bring patients into their healing experience to create a meaningful recovery process for patients, nurses also cannot live a meaningful life for their patients and instead must help patients to find meaning in their own lives (Henderson, *Basic Principles of Nursing Care* 23, 27). This idea clearly speaks to the time in which Henderson was writing and the increasing questions being raised around issues stemming from the advancement of medicine allowing for the idea of drawn out terminal illnesses. These questions around meaning and illness also would eventually become the foundational questions that would shape the hospice and palliative care movements in America at the end of the 20th century.

The work of Virginia Henderson in many ways served as a bridge between the rigid and Victorian-based practices and structures of professional nursing established by Florence Nightingale and the culture of increasing recognition of the benefits of compassion-based medical practices that allowed for the development of the hospice and palliative care movements at the end of the 20th century.

Henderson's definition of nursing may at first seem simple and self-explanatory. However, when one examines the subtle nuances of her argument around the ideas

of the central roles of medical practice and the need for true patient care, it becomes obvious just how encompassing of nursing practice, theory, and research her philosophy truly is (Henderson, "The Concept of Nursing" 26). Henderson's work set out the course for modern nursing training and formulated many ideas around nursing that had been known, but not clearly articulated. Her work particularly clarified the importance of what compassion-based care meant in practice and the inherent qualities that were needed in nursing training to develop those skills. She realized that nurses needed an understanding of humanity and the environments they were practicing and living in (Henderson, "The Concept of Nursing" 21). Henderson's work was also crucial in unifying the field of nursing and providing a standard and model by which all nurses could be educated and trained in a common mindset by which the field could solidify (Arnstein xv). This model allowed the field of nursing to be unified in its broader goals and provided a clear explanation for the questions that became prevalent in the second half of the 20th century around the subtle differences between nursing and other forms of medical practice (Henderson, "The Concept of Nursing" 25). In her own ways Virginia Henderson was as instrumental as Florence Nightingale in allowing the field of professional nursing to survive, thrive, and grow. The field of nursing was able to evolve in the mid-1900s with the structure provided by Henderson's definition of nursing.

Perhaps the most symbolic event of Virginia Henderson's influence on the field of nursing occurred when students at the Emory School of Nursing presented Henderson with gold nail clippers in honor of her command to, "cut their toenails," a reminder to nursing students that it is the smallest of tasks that are crucial to a

patient's overall health and it is the responsibility of nurses, as practitioners of compassion-based care, to ensure these needs are being met (Halloran 3).

Henderson devoted not only her career, but also her life, to helping to improve the lives of the patients she came across. She set the tone and provided the example for many modern nursing leaders, almost all of whom were influenced heavily by her belief, that central to nursing was a humility and true willingness and desire to help the whole aspect of a patient and their family (Arnstein xv). Especially in a time when science and medicine were still almost exclusively male, Henderson, herself acutely aware of the strong gendered stigmas against nursing, decided to still boldly solidify nursing's connections with the ideas of compassion and motherhood. She chose to acknowledge and appreciate the field's feminine-based associations and celebrate the values of physical care.

Much of the reason for the long-term success and longevity of Henderson's work was due to her willingness to acknowledge that the field would be constantly evolving and changing. She knew that her work must be specific to make meaningful change, but also broad enough to fit into a growing medical field (Henderson, *Basic Principles of Nursing Care* 21, Henderson, *Contemporary American Leaders In Nursing* 121). Henderson was also able to foresee the future of nursing in a number of surprisingly accurate ways. She postulated many ways in which her ideas would be utilized in nursing in the future. Henderson correctly warned that many early nursing tasks of the late 19th century and early 20th century would soon be increasingly "outsourced" to other specialized positions such as physical therapists and dieticians. This outsourcing would cause many people only aware of the "task

oriented” aspects of nursing to question the roles of nursing in modern medicine (Henderson, “The Concept of Nursing” 24). She was also able to correctly predict how the rapid growth of medical technology would change medicine and correctly imagine how the role of nursing, and the ability to provide human touch, would become increasingly important (Henderson, “The Essence of Nursing in High Technology 23).

Perhaps most importantly, Henderson was actively aware of the struggles that would come around the evolving movements for autonomy for advanced practice nurses and the gender-bias that would continue to plague nursing as a female-gendered and led field (Arnstein xiii-xv). Henderson strongly believed that the route to combatting these challenges based in sexism was to bring nursing, originated as a very practical field, into the academic realm. For this reason, she fought for much of her career to create a strong tradition of nursing research that incorporated the humanities with science. She believed asking these types of questions would allow nursing research to go deeper than most other forms of medical research (Lazenby E10). There have been great changes to the field of nursing theory since the period in which Virginia Henderson’s theories and practices were developed. However, it is still Henderson’s definition detailing the virtues of compassion-based medical care and her needs theory that remains at the heart of almost all nursing practice and which would serve as the foundation of the American End-of-Life Movement. In this way her mark on the field of nursing remains indelible.

Florence Wald: How One Women Used The Model of Compassion-Based Care To Change The Way Americans Die

“One of the most pressing social and cultural issues of our time: the humane use of medicine and healthcare.”

-Florence Wald

By the time that Florence Schorske Wald entered the field of nursing the work of Florence Nightingale and Virginia Henderson had clearly established, for both better and for worse, the priorities and expectations of nurses with the work they did around the ideas of compassion and patient-directed care. Wald has become particularly known for her contributions to modern medicine in the form of her development and implementation of hospice and palliative care in America, which would come to define the American End-of-Life movement. It is particularly by looking at the work of her entire life, however, and the principles she stood for, that one begins to fully appreciate how Wald truly influenced, and greatly improved the fields of nursing and medicine as a whole.

Florence Wald, like many of the nursing leaders who preceded her, was a fiercely intelligent woman who was prepared to push within and fight outside of the established system. She sought not only further the medical practice innovations she saw as necessary for patient care, but also to gain respect and appreciation for the work of nurses in a time when she was often the only woman at the table and viewed as such. Wald was also lucky in many ways that she was undertaking her groundbreaking work in the mid-to-late 20th century when the women’s liberation movement and other social justice causes were increasingly breaking down many of the limiting structures that had existed since before the period of Florence

Nightingale. This is not to understate the amazing and revolutionary work that Wald undertook around implementing perhaps the best-known practice of compassion-based care in the modern medical system. In many ways the work of Florence Wald is an indication of her strength, intelligence, and perseverance as well as the devotion, intellect, and courage of the many women who came before her in the field of nursing. Wald was a product of a long line of nurses who worked within their place in the medical system and resisted pressure to conform to male-centered ideals of healing and health to create the field of modern nursing. Florence Wald took nursing a step further, which led to the creation of the American End-Of-Life Movement.

Perhaps the most common comment those who met and worked with Wald are quick to make is about her kind and compassionate demeanor and her lifelong commitment to mentorship (Gilliss 343, Adams 129, "Tribute to Florence Wald" McCorkle). These qualities are not only a testimony to who Wald was as a person, but also to what she strongly believed was central to good healthcare. In many ways it is impossible to separate Wald's values from her work on the hospice movement and the central philosophies Wald advocated for when reimagining the dying process. Wald was the product of many factors in both her personal and professional lives that converged with her place in history. She was influenced and motivated by factors that allowed her to emerge from nearly a century of nursing theory, philosophy, and practice and put into place what can be argued as the greatest tangible outcome of the growing field of American compassion-based medicine: the American End-Of-Life Movement.

Born in 1917 in the Bronx, Florence Schorske Wald was exposed from an early age to the ideas of kindness, love, care, and equality for all (Block 285). Wald's parents were active in a variety of social justice based causes. They helped to teach immigrants on New York's Lower East Side to read in the 1920s, and raised Wald and her brother Carl to be well educated in a variety of ways and subjects (Block 286). Wald was also heavily influenced by her parent's fierce Socialism and deep pacifist beliefs (Block 292). This upbringing deeply rooted in ideas of universal equality and compassion, especially in a period of tension and inequality both domestically and abroad, would ingrain Wald with deep-seated beliefs about the world and how people should be fundamentally treated. These ideas would later directly influence her practices around hospice care. Despite the generally positive upbringing Wald experienced, life was not perfect in her early childhood. She experienced a number of health issues as a young child that required frequent hospitalizations. She would later reflect on the isolating experience of being hospitalized in a highly institutionalized medical setting and it affected her decisions as a healthcare provider (Block 285). Wald was particularly led to nursing following a multiple week hospital stay in Washington D.C. at the age of seven when she came down with Scarlet Fever while returning home with her family. Forced into isolation and separated from her parents, Wald would later reflect that it was the care of her nurse, Eunice Biller, who treated her as a person and not a disease, that would shape many of her own practices as a nurse (Block 295). As Wald grew older, she also came to be heavily influenced by the combination of her parents' great pride in their German heritage and their deep beliefs in pacifism, which led them to strongly

condemn the actions of Germany during World War II from the outset (Block 294). This culture in Wald's upbringing of feeling comfortable questioning authority and fighting for peace and justice would later help Wald to push back against many of the sexist barriers in place for nurses in the late 20th century and allow her to push for a medical movement around compassion and care.

Wald was also heavily influenced as a child by the extensive sexism that she observed, both in the world as a whole and in her immediate family. Particularly Wald was frustrated to see a tradition of women in her family being offered various educational opportunities, only to be relegated to the home once they were of childbearing age with the expectation that they would cook and clean for their working husbands (Block 287). This expectation was especially frightening for Wald, who had grown up observing both the great pride her parents took in her brother's developing intellect and the great frustration her mother faced from having to leave her career after marriage. This knowledge instilled in Wald a fear of marriage and a strong desire to fight to have a career outside of the home (Block 288). Though Wald would eventually manage to both marry and have a prolific career outside of the home, her strictly gendered upbringing would stay with her. Used to having to advocate for herself and project confidence in her intellect and skill, Wald grew to be a leader in the nursing field. Eventually she also gained respect and support in the field of medicine as a whole while remaining true to her core values of compassionate care - a revolutionary feat in many ways.

Though Wald's father had forbade her from going to college, her mother and brother lied to him so that she could apply to Mount Holyoke College, which she was

allowed to attend after being accepted. Between 1924 and 1955 Mount Holyoke College sent more graduates to the Yale School of Nursing than any other college. Yale School of Nursing was quickly establishing itself as the home for evolving nursing theory, a sign of the increasing movement of the field of nursing into the academic realm. Florence Wald found a home at Yale School of Nursing (Block 296, Diers 300). Wald graduated from the Yale School of Nursing with preparation to be a nurse with advanced responsibilities in 1941 and soon after began teaching nursing (Wald 1683). For a long time Wald felt unsatisfied with her life and career as a nurse, feeling that she was languishing working in various labs and hospitals and repeatedly coming up against gender barriers. As a result she often referred to these as her “lost years” (Block 297). It was not until she took a job at Babies Hospital through Columbia-Presbyterian and had a monumental experience as a “change agent” after successfully fighting to extend the visiting hours policy so that parents could feed their babies dinner. After that she felt reinvigorated (Block 298). Wald decided to return to Yale to enroll in their new program in mental health nursing, which, along with public health nursing, was becoming increasingly popular with independent minded nurses. These areas of nursing removed nurses in many ways from the hierarchy of the traditional hospital (Diers 302). Once back at Yale, she quickly ascended to the office of dean of the failing school of nursing. Wald found her place fighting for the importance of nursing and eventually crafted the early plans for hospice and palliative care around her experiences observing the poor ways in which many people were dying and the ways in which a compassion-based

approach could alter this trend. Under her strong but caring leadership the American End-Of-Life Movement had begun.

It is hard in many ways to separate the work Florence Wald did at the Yale School of Nursing (YSN) from her later work around the founding of hospice and palliative care in America. When Wald returned to YSN in 1955 to begin studying for her Master of Science in mental health, the nursing school was in danger of being ruined by the ideas of then Yale University President, A. Whitney Griswold, who wanted to focus the university in the liberal arts and away from technically-focused graduate schools (Diers 302). The School of Education had already disintegrated with the Nursing School, Law School, and Medical School expected to follow soon afterwards. Wald, seeing the path the School of Nursing was headed for, and understanding the implications that would occur if advanced preparation for nurses ceased to exist, returned to YSN with the goal of strengthening the programs offered and saving the school (Diers 302). Shortly after returning to Yale, Wald was offered the deanship of the School of Nursing and was given 5 years to turn the school around. Wald started immediately implementing many of her philosophies for nursing as both a self-proclaimed scientist and humanist (Diers 304). Wald also insisted on creating better-rounded and collaborative nurses. She built upon the ideas put forth by many nursing theorists before her, including Florence Nightingale and Virginia Henderson, of interdisciplinary collaboration, especially between the various fields of medicine (Adams 127). Wald was also instrumental in returning the focus of nursing research to be practice-based instead of stuck in the theoretical. Wald felt strongly that the essence of nursing was in practice and the physical and

emotional connection with patients (Diers 305). Though many, both within YSN and in the larger nursing community, felt Wald's practices and theories around nursing research would limit progress and hurt the field, this quickly became a null point as YSN students began to rise to prominence and gain national attention for their research. This success was largely because of Wald's insistence that every YSN student do research under the guidance of advisors in the aspects of methodology, clinical, and writing and because of the close proximity YSN students conducting research had to real patients, something many nurse researchers had not experienced in years (Diers 306-307). The early years of Florence Wald's time at Yale, particularly in regards to the work she did around solidifying the role of patient involvement and contact in nursing research, would in many ways set the stage for Wald's later work with hospice.

Another important development of Wald's time at Yale was her establishment as a leader in the field of nursing and how her visibility as a female leader functioning in many all-male spaces helped to open the field in many ways and increased the drive for nursing autonomy. Central to Florence Wald's efforts to keep YSN open was her desire to solidify the development of nursing as a science, equal to that of any other male dominated disciplines, such as traditional medicine (Diers 303). Wald was working in a period when nursing research assistants at large hospitals still often received no credit when research they helped with was published. Wald realized the importance of establishing both within the realms of practice and academia, that nursing was a legitimate field of academic and scientific study that refused to forfeit many of its compassion-based practices and beliefs to

conform to other traditionally male models of medical practice (Diers 301). As would be expected Wald was ahead of her time even for many of her nursing colleagues. As a result she often faced resistance to her ideas about nursing and gender equality (Diers 310). Working to be accepted and respected in the almost exclusively male world of advanced medicine, and particularly navigating the almost entirely male Yale universe as the only female dean, Wald had little choice but to be confident and to fight for what she knew to be right, both as a person and as a well-trained nurse (Diers 304). To combat and circumnavigate many of the hostile environments that she ran up against, Wald was judicious in seeking out collaborators, mentors, and teammates, both within the School of Nursing and in the wider community. Regardless of their perceived academic prestige, seniority, or influence, she sought colleagues who would work with her to put her beliefs about the future of medicine into practice (Vachon 323, Wald 1683). In this way Wald was able to achieve the multidisciplinary collaboration and success she desired.

As Florence Wald's work around compassionate medical care continued to develop over the course of her time at Yale, she was increasingly struck by the lack of patient choice in their medical care, especially around the topic of death from chronic illness (Wald 1683). Following the end of World War II, much of the focus of American medicine has shifted to focus on cure-based measures and disease driven treatments, with little attention paid to the needs or desires of dying patients and their families (Adams 125-126). As medical technology and battlefield medicine had improved, the idea that death was something that could be put off became increasingly popular. Much of Wald's movement to introduce hospice care to

America and to provide Americans with a choice in how they died was founded from the central philosophy of nursing rooted in patient-directed care. In 1965, after hearing a talk at the Yale School of Nursing by Cicely Saunders, the founder of St. Christopher's Hospice, the world's first hospice, Wald quit her deanship at Yale in 1967 to go to England and study under Saunders (Hoffmann 26, Wald 1683, Adams 127). Wald opened the first American hospice service upon her return, first as a homecare service in the early 1970s and then as an inpatient service in 1980 (Wald 1683). For Wald the philosophy of hospice care answered many of the concerns she had about the anxieties she had observed in patients facing death. To prepare herself and her team to implement hospice practices in America, in 1969 Wald engaged in a two-year interdisciplinary study, utilizing the unique knowledge of community leaders, clergy, and other health care providers. She and her team kept detailed diaries of the needs and thoughts of terminally ill patients to collect evidential research that could direct meaningful change (Adams 125, Wald 1684). Wald's approach in having honest conversations with patients and their families about their personal experiences with their illness and treatment, as well as their impending death, was revolutionary in a time when many nurses were forbidden by doctors from answering patients' questions (Wald 1683). Perhaps most revolutionary about Florence Wald was that she was not afraid to acknowledge, and even embrace, death believing that it is just a part of life (Gilliss 345, Block 295). Once Wald was able to move past many of the societal avoidances of death, she was able to honestly and openly converse with her patients about death and in the process help them with preparing to die. For many of the early hospice patients

Wald saw, and still for many terminally ill patients receiving hospice services, hospice professionals were the only people who they could openly discuss their various feelings about death with in an honest, safe, and comforting way. Important also to Wald's theories about end-of-life care and providing people with choice in how they die was her strong belief that not everyone wants a "peaceful" death and that for some patients and their families taking life-prolonging measures for as long as possible is the best option. Ultimately Wald believed it was up to a patient and their family, and not healthcare professionals, about how they want to find meaning and ultimately die (Wald 1684). For Wald the goal of creating hospice was not that everyone needed to die in the specific way that she saw as best, but instead that American end-of-life care should be based around lived experiences of death and grief (Adams 130). Wald was a strong believer that everyone, as a basic human right, was entitled to die in a way that felt safe and comfortable for them and which could provide meaning to their life. For this reason in 1995, when Wald was approaching her 80s, she reached out to connections she had in Connecticut's prison system. She implemented programs in prisons training inmates to work as hospice volunteers for terminally ill fellow prisoners, training many of the early volunteers herself (Thompson 363). Wald was correct in her prediction that these programs would be beneficial in providing both skills to incarcerated people that would be useful after leaving prison, and in providing meaningful and compassionate end-of-life care to people who were, for various reasons, going to die while still incarcerated. In the 20 years since Wald started these programs, they have become tremendously popular across the United States, with many past volunteers going on

to become CNAs following the end of their sentences (Thompson 376). The American End-Of-Life Movement started by Wald and her colleagues was bigger than just a movement to improve the ways in which people die, it was a movement about the need for compassion-based and patient directed care and for the importance of choice in medicine. Nurses had been fighting since the beginning of the field for a voice and an acknowledgement of their unique knowledge of patient needs. Florence Wald happened to be the right voice at the right time to finally, after almost 100 years, be allowed by society to start a compassion-based and nursing led major medical movement. Even as the ideas of hospice and palliative care have grown in popularity, nurses are increasingly being phased out of the history of the movement in favor of spotlighting physician and other traditionally male voices who have only recently come to advocate for the movement.

As Cynthia Adams argues in her study applying J.M. Burns's theory of Transformational Leadership, Florence Wald had the qualities of a transformational leader to successfully implement her movement both for hospice care in America and for the more general appreciation and implementation of compassion-based medicine in America (Adams 130). In many ways it is these qualities of great leadership that make the work of Wald not only more impressive, but also more important. Wald developed a strong aspect of caring to her leadership, not only helping people to embrace her ideas, but also helping to develop and support the ideas of those she mentored, which was nearly anyone who crossed her path (Adams 125). Wald was lucky to be working in a period when counter-cultural urges were increasingly encouraging Americans to question authority, including doctors

educated in the traditional model, but it cannot be denied that she possessed, and utilized, incredible leadership qualities in her movements around nursing and hospice care specifically (Adams 130).

It was under Wald's leadership and vision that much of nursing shifted once again, moving to be highly patient centered after pushes to fit the field into the traditional male medical model had briefly begun to move it away from these values (Vachon 323). Healthcare was, and continues to be, rapidly changing. As a result the moment was right for Wald to put forth her great paradigm shift in not only the ways in which we die, but also in how we live, because the work of Wald was as much about living as it was about dying (Adams 126). In asserting that people had the right to exit life in a way that felt meaningful for them, Wald was also advocating what nurses had known for centuries: that well and unwell cannot exist without each other and that in working to restore health, one must not lose sight of the person within the illness. Through her work with the founding of the American End-Of-Life Movement, Florence Wald changed thousands of people's lives by changing the way they died and helped to start one of the most monumental changes in how American healthcare is practiced in the history of medicine.

Hospice and Palliative Care In America: The Importance of Choice and Compassion In End-of-Life Care

When one begins to consider how quickly Florence Wald's hospice movement took off, it is almost hard to comprehend. Within 15 years of Wald founding the first modern American hospice, Connecticut Hospice, in Branford, Connecticut, there were over 1000 American hospices (Adams 125). The speed and scope of the American End-of-Life movement, and conversations around how American's die in contrast to how they want to die, is a clear testament to the great importance of the work Wald set out to do. The increasing popularity of the American End-of-Life Movement also speaks to the unfilled need that remains for honest conversations around difficult topics in medicine, particularly death, and for a more compassionate approach to healthcare. The hospice and palliative care movements are important in the gendered history of nursing for several reasons. The American End-of-Life Movement represents one of the first wide scale cases of nursing being able to successfully shape a medical movement around a compassion-based model of healthcare. Perhaps deeper for the field though, is in the autonomy, respect, trust, and independence the American End-of-Life Movement offered to the field of nursing by moving healthcare outside of the hierarchical hospital setting and by allowing for nurses to remove themselves from many of the patriarchal settings in which they had previously been forced to exist. Within the hospice and palliative care settings nurses were able to redefine their roles and structure these systems to give themselves the higher levels of autonomy they deserve (Hoffmann 30). By taking on many of the leadership position in the modern American movement

around compassion-based end-of-life care, nurses were able to define the roles they would play in hospice and palliative care in ways they had never before been afforded the option in the history of healthcare.

Equally important as looking at ways the hospice and palliative care movements have shaped nursing and efforts for autonomy, is to examine how the philosophies of nursing, particularly around the ideas of gendered assumptions of physical care, have shaped the hospice and palliative care movements. In many ways it was natural that nurses would be the medical professionals to take on the plights and concerns of the often ignored and marginalized gerontological population. Much of nurses' work had become focused on helping these older patients, both in the acute and primary care settings (Remington and Wakim 20). For this reason the transition of nursing into the compassionate end-of-life setting was a natural step. The major focus in nursing on patient directed care, particularly following the work of Virginia Henderson, also allowed nursing to be open and honest with patients around conversations about end-of-life care and how they, as a unique individual, wanted to die. The natural structure of nursing allowed for nurses to be honest with patients when addressing various fears and societal pressures around death and dying, especially around the idea that accepting hospice or palliative care is giving up on life (Remington and Wakim 19, Adams 127). This was something physician practiced medicine had been struggling with for nearly its entire existence (Hoffmann 27). Given the natural, and fundamental role nurses played in the American End-Of-Life Movement, it is frustrating to see the hijacking of the movement in many ways by, typically male, physicians, notably author-

physician, Atul Gawande. Recent efforts have begun to attempt to place hospice and palliative care within the highly controlled patriarchal medical model, which has begun to change the movement overall. Looking at how hospice can influence medicine moving forward is interesting both for what it says about the potential for medicine to change for the better moving forward, and for the ways in which hospice and palliative care have already begun to change, moving from the nursing philosophies on which they were founded, to conform to hierarchical and institutionalized practices of medicine.

Although it is easy to see the benefits provided to medicine and the American End-of-Life Movement by the central involvement of nurses in the development of hospice and palliative care practices, this movement was also an important development towards finally giving the respect and autonomy that nurses deserve for their often misunderstood work. The American End-of-Life movement of the late 20th century gave nurses and nursing theory not only the opportunity to serve as the leaders and developers of a major medical movement, but it also allowed nurses to take on clinical leadership positions and removed them from the male dominated systems that had held the profession back from its true potential for years. While the results of the movements around hospice and palliative care did not achieve as many of the changes around increased autonomy for nurses that it should have, it is one of the clearest examples of nurses seeing a problem in healthcare and stepping forward to remedy it when no one else wanted to pay attention (Adams 126). In many ways it was natural that nurses would play a fundamental role in the development of a new end-of-life care model based around patient concerns. The

inherent philosophies of nursing are conducive to this type of patient centered care. But in addition, it was a natural result simply because of the incredibly close relationships nurses can form with their patients as a result of the direct care and patient advocacy work they perform (Hoffmann 33). It is also this close connection that is the reason most professional service providers in hospice are still nurses (Hoffmann 30). Nursing in its most idyllic form naturally allows for close human relationships to form. The recent attention that has been given to hospice and palliative care options in America has allowed for this central aspect of nursing to be spotlighted. In many ways this close connection between nursing and compassionate care and the rise of the American hospice movement in the late 1960s and early 1970s is logical given the shift in social movements of the period. Following World War II, death increasingly moved from the home to the hospital, as women's liberation movements allowed for women, who previously would have cared for ill and elderly family members, to begin working outside of the home. This social change required the professionalization of end-of-life care (Adams 126).

As death moved into the hospital and the cure-based realm of traditional medicine, it was easy for the importance of compassionate end-of-life care to be forgotten in the growing obsession of the mid-to-late 1900s around increasing abilities to cure disease and prolong life (Keegan 8). Previously this care had been provided, much as compassionate home-based childcare is, as a result of close personal relationships. For this reason the ability of nurses to provide skilled nursing care-based in a broader context than just that of prolonging life was particularly appreciated, valued, and recognized by terminally ill patients. Without

hospice and palliative care options, these patients would have little choice in how they die. In many ways this was the first large-scale appreciation in modern medicine of a compassion-based medical practice. The distinction between acute care end-of-life settings, such as intensive care units, and hospice settings, whether they be an inpatient hospice facility or home-based hospice care, may not seem dramatic now. However, when the concept was first suggested, Yale New Haven Hospital, the hospital with which Florence Wald was associated, refused to allow for hospice within the hospital (“Tribute to Florence Wald” McCorkle). This was fine with Wald who firmly believed that it was important to establish hospice outside of the hospital to provide both a variety of treatment options for patients as well as autonomy for the practitioners of hospice care, primarily nurses (Wald 1684). This distinct separation from the hospital, where nearly the entirety of nursing history had taken place, was what allowed, in many ways, for nurses to finally have the authority and freedom to practice as they knew was best, without the constricting oversight of still primarily male physicians. In many ways the hospice movement has only begun to gain widespread popularity and attention since it has begun to be moved into the realm of the physician. It is ironic to see the endorsements and attention from mostly male physicians, who have begun finally, after almost 50 years, to tout the validity of end of life care not based in life prolonging measures (Siebold 81). While it is a positive development for the hospice and palliative care movements that they are finally beginning to receive widespread support and validation from within the physician-dominated medical establishment, it is also

important to acknowledge the role this plays in erasing the work and success of the nurses who developed, led, and staffed the American End-of-Life Movement.

The development of hospice and palliative in America are also important in the context of the gendered history of nursing for the implications they have in the value of care-based medical practices and for what they say about the need for traditionally female-associated traits in medicine. In many ways prior to the late 20th century when the term “quality of life” became a popular concept, there was little consideration to how medicine influenced people’s lives (Siebold 35). In many ways this was true for most of human history as end-of-life care was not something people needed to seriously consider as terminal illness was not a common reality. Given the agricultural history of the United States, death was a common part of ordinary life and people often times died suddenly or shortly after getting sick, with little medical intervention involved (Keegan 6).

In many ways nursing was also central to shaping the compassion-based American End-of-Life Movement in ways deeper than just nursing philosophy in that it moved it away from the historically male realm of medicine. As the modern American movements around hospice and palliative care began, traditionally male models of medical practice and education had come to view death and compassion-based models of end-of-life care, as quitting. Death was viewed as something that men could conquer in a patriarchal society and therefore served as an insult to the scientific advances of male led 20th century science (Siebold 38). This need to exert male dominance also led to the medical culture of physicians making decisions for patients and their families instead of with patients and their families (Siebold 43).

This focus on a correlation in physician success with cure, measured by rates of cure, has only further enforced the idea that compassion does not have a clear place in medicine. It is impossible to ascertain how kind and compassionate one is in quantitative measures, which serve as the epitome of empirical science (Hadlock 104). For this reason early nurses in hospice felt strongly that compassionate care centered around death must be removed in its basic nature and principles from the hospital, similarly to how the practice of midwifery, another movement of compassion-based care lead and staffed by nurses, removed birth, in philosophy and basic practice, from the hospital mindset and model of medical practice (Wald 1684, Vachon 320). There are strong parallels for many nurses and other practitioners involved in the American End-of-Life Movement between birth and death. The general population has a growing comfort with birth but not death. Hence, there is a strong push within the hospice and palliative care movements to approach end-of-life care as both whole patient and whole caregiver care. Supports of this effort particularly hope to emphasize the role that medical practitioners play in the process of death as both a professional and as a person (Vachon 329). For this reason, and closely tying back to the model of midwifery, there has been an increasing focus on the idea of separating end-of-life care into the three phases of pre-death, death, and post-death. There have also been efforts to involve families in the dying process through tasks such as basic nursing training to allow loved ones to provide physical care and through bereavement follow up care, which has been shown to benefit patients and their families in a multitude of ways (Hoffmann 29-30). The values of many of the central philosophies of nursing and those of hospice

and palliative care are incredibly similar because in many ways these movements are extensions of the nursing profession. When nurses, and other health professionals interested in compassion-based medicine, saw a problem within the medical establishment around the choices people had of how to die, they chose to move outside of the hierarchical system of patriarchy that failed to see the value in care, versus cure, based medicine and created a movement of their own. In many ways this serves as an example of how the field of nursing can help to positively shape medicine moving forward.

There is little doubt, between rising healthcare costs and the increasing institutionalization of medicine, that something needs to be done to rectify the increasingly urgent healthcare crisis occurring in the United States. In many ways the work of nurses within hospice and palliative care, as well as the American End-of-Life movement as a whole, can be used as a case study for the role nurses and compassion-based medicine can play in improving American healthcare. Still despite the many successes of the American End-of-Life movement, many barriers exist to successful access to hospice and palliative care services. In 2008, only 38.5% of US deaths occurred while a patient was in hospice care and even then most patients who received hospice care were white women over the age of 65 (Remington and Wakim 17). This statistic is likely due to the way hospice and palliative care are presented in the American medical system, which is still very reluctant to embrace death as the final reality for all patients, giving hospice and palliative care a feeling of frightening finality (Wald 1684). This is especially unfortunate given that research has shown that hospice and palliative care can best

serve patients when they are referred to these services with time to fully embrace these models of care before they die (Remington and Wakim 18, “What Makes a Death Good? Strong Values, High Values, and Hospice Care” Stephen Latham). Due to much of the reluctance among medical professionals practicing in the cure-based model of care though, there still remains a hesitancy among many acute and primary care providers to recommend hospice and palliative care services and a misunderstanding about what hospice and palliative care actually entails (Remington and Wakim 18-20). This phenomenon leads to many patients who would prefer to die in the comfort of their own home, or an environment similar to their home, dying in a hospital, alone and after having received invasive life prolonging measures that they did not actually want (Remington and Wakim 19, Hoffmann 31). In many ways a paradox exists for hospice care as it does for many other forms of compassion-based forms of medicine where central to these practices of medicine is their distance from the mainstream patriarchal and hierarchy based practice of cure-based medicine. However to receive widespread use, acceptance, and to be as beneficial as possible, these services must exist, to some degree, within the accepted and mainstream system of medicine. A particularly strong example of this can be seen in the increasing movement of midwives into the hospital setting. As the American geriatric population grows and as patients live longer, it is increasingly becoming important that all medical providers be educated and encouraged to speak frankly with their patients about end-of-life care so that patients are educated on what their options are and how they can qualify for various services (Hoffmann 33). These changes will be

important moving forward in medicine because they mark a movement towards a medical system with a higher value placed on traits seen as traditionally female, such as compassion and emotional support, which have been shown to reduce medical costs and provide better treatment to patients (Remington and Wakim 18). These qualities in medical care are often ignored in favor of traditionally male-traits in medicine, particularly around the idea of cure and conquering of disease (“What Makes a Death Good? Strong Values, High Values, and Hospice Care” Stephen Latham).

Looking at the needs of medicine moving forward, it will be important to examine how compassion-based medicine can better be incorporated into mainstream medical practices while still maintaining the original goals and integrity of the initial movement. This especially begins in the way students in the health professions, particularly students preparing to become physicians, are taught to approach death and topics of dying, both with patients and families, as well as with their various medical colleagues. This is particularly important in light of discoveries, such as that of a Dutch survey, which found that often the concerns of patients differ greatly from what their medical professionals think they fear (Keegan 146). Though most medical school curriculums included little education about death other than the necessary clinical facts prior to the 1970s, increasingly medical schools are recognizing that while medicine is interested primarily in description, observation, measurement, and categorization these skills can only describe death. The descriptions do not frame death and that it is necessary to approach the topic of death with medical professionals in more dynamic and nuanced ways (McCullough

186, Goodell, Donohue, and Benoliel 69). This is particularly important as the field of end-of-life care continues to evolve to give patients a greater amount of choice. Death education for medical professionals needs to begin to reach deeper than just sensitivity to also educate on the differences in choice and how medical professionals can best help their patients to make choices around death and dying that will suit the needs of the patient and their families in creating a meaningful death experience (Benoliel ix). While it may seem simple initially to discuss the education and practice around death and dying, the various social questions and feelings of discomfort that these conversations bring up are clear indications that the close ties every person has to death require greater care when approaching these topics in an honest way. Both in the present and into the future medicine will need to think broader and begin to adapt to many of the compassion-based perspectives medical fields, such as nursing, have been advocating in favor of for decades.

The growth of the modern American hospice movement since its founding approximately 50 years ago has been astounding. Alone between 1980 and 1985 the number of American hospice providers increased from 200 to 1500 (Siebold vii). This has marked an incredible increase in awareness of the benefits of compassion-based care, particularly in end-of-life care, and has helped in many ways to remove nurses and other compassion-based medical professionals from the hierarchy of the hospital that had held them back for so many years. The American End-of-Life Movement also exposed many patients, families, and practitioners to the benefits of medical practices based in the often female-associated traits of emotionally based

and interdisciplinary hands-on care that modern male-dominated medicine has avoided fully embracing. Still, the hospice movement has not been fully embraced by all, especially when compared to the success of the European end-of-life movements. A likely reason is because the level of physician domination in the US is not paralleled in many European medical systems (Siebold 22). Many educated in the traditional model of cure-based medicine have been reluctant to adopt medical practices they see as giving up on patients and allowing them to die and as a result widespread growth of the availability for patients to die in compassion-based settings has been slower than many would like. The paradox remains that until hospice and palliative care are widely accepted and advocated for by physicians and those with dominant voices in the mainstream medical community, these treatment options will continue to remain underused. Many also fear though that by allowing the historically male based medical establishment to coopt the hospice and palliative care movements, inherently much of the compassion-based aspects, and the due credit of the nurses who founded the movement, will be lost. However, as medical costs continue to rise and patients continue to receive overaggressive end-of-life medical treatments, often performed more for the benefit of the medical practitioner than the patient, the American medical system will continue to be severely flawed (Siebold 1). It is becoming more crucial than ever in the American medical system that a major overhaul occurs and all medical practitioners begin to become educated and aware of the needs for both compassion-based and cure-based medical options.

Conclusion: The Evolving Role Of The Nurse

As stereotypes around gender and barriers to entry for women in the sciences are recognized and slowly rectified, the field of nursing remains uniquely stalwart. Whereas only 50 years ago women looking for a career outside of the home had little choice other than “caring” professions, mainly teaching, nursing, and working as a secretary, now the options for women, at least superficially, are increasing (Huppatz 70). As nursing has become a choice rather than a limited career option for women, long held stigmas surrounding nursing, largely related to its gendered associations, have become more prominent in society. Many question why a person, especially one with the opportunity to become a physician, would choose to pursue nursing instead. This opinion is a clear indication of how far American society has to go in understanding the roles of nurses and the value of medical practices based in a philosophy of care. This point of view is also a clear indicator of the inherent sexism that remains in medicine and the sciences where the general opinion remains that women should happily flock to traditionally male fields, abandoning the vital work of fields such as nursing, when given the opportunity to make a patriarchal bargain.

As the gendered history of nursing progresses into the present and future of medicine, it will be interesting to see how medicine will adapt and develop. This is especially true as nursing is increasingly changing and evolving to answer questions that continue to be asked around its history as a field developed and maintained primarily by women. It is also interesting to note that the equivalent questions are

rarely asked of historically male fields and the efforts through advanced compensation traditionally offered to male nurses, has not been reciprocated in fields such as physician-based medicine or finance to attract women to these male dominated fields (Muench et. al 1265). The increasing entrance of men into the field of nursing is also bringing up many questions about the way gendered work is conceptualized and the ways in which society chooses to depict, characterize, and view men who are seen as doing “women’s” work.

Particularly important to note in the modern gender history of nursing is the current debate around autonomy for nurse practitioners, and the reluctance, mainly from physicians and those outside of the world of nursing, about what it will mean to allow highly trained nurses, who have historically been female, to practice without the direct supervision of physicians, who historically have been male. This is an especially important and frustrating debate as many argue that nurse practitioners will be crucial in providing effective primary care to patients as an increasing shortage of primary care providers in the United States grows (Poghosyan, Boyd, and Knutson 472, U.S. Census Bureau 2). It also speaks to the continued domination of the hierarchical and patriarchal based mindset of modern medicine as well as the resistance to embrace alternative approaches to healthcare. This is especially troubling as many of these alternative approaches to healthcare could shift the application of many types of healthcare away from the cure-focused approach of the medical institution and into various interpersonal and compassion-based healthcare applications, similar to that seen in the hospice and palliative care movements. Nursing currently sits on the precipice of a potentially great change. It

will be crucial moving forward that the gendered history of nursing is celebrated and embraced and that the compassion and physical care aspects of nursing that have been used to degrade and hold the field back for so long are finally embraced and used to change medicine for the better.

The gendered history of nursing in many ways has two stages: the past, as one of the few almost exclusively all-female fields, and the future, which will detail the evolution of nursing as it opens to the general population. Both stages provide interesting insight into the roles of gender in American society and expose interesting and nuanced perspectives on how the expectations and associations of gender in America shape the work, behaviors, and spaces we expect people to act in, especially in regards to the sciences. Increasingly as pushes for gender equality have allowed women to begin entering traditionally male fields, efforts to reduce the gendering of professions have also seen increases in the number of men who now choose to pursue nursing, with 9.6 percent of registered nurses being men in 2011, compared to 2.7 percent of registered nurses being men in 1970 (U.S. Census Bureau 2). This fairly rapid shift in the gender demographics of nursing has led to many questions of gender both from within and from outside of nursing. Even the term “male nurse” a common way of describing a man who chooses to work as a nurse is unique in that there are few other non-gendered profession titles that are specifically gendered to describe a person and their assumed character. Many of the gendered assumptions about men being linked to the cultural and intellectual, and not to the body, also result in depictions of male nurses that either hold highly feminine characteristics or who are seen as colder and more removed than female

nurses (Huppatz 68). The public depictions and assumptions about men who choose to enter the field of nursing also creates a level of suspicion as to why they would want to take on caring-based work (Huppatz 85). This is an interesting paradox when examined in the context that few question why women would want to enter traditionally male fields, such as law or medicine, which are seen as prestigious and coveted occupations that women are lucky to now have available to them. In many ways this social resistance to the idea of men doing the perceived work of women speaks to the ways in which society values men and perceived tasks of masculinity, mainly in the context, cure, conquer, and the power this brings over women and compassion-based tasks.

The entering of men into the profession of nursing has also raised many questions around the compensation provided based on gender. Though women strongly outnumber men in the profession of nursing, and though women founded and developed the field of nursing, pay gaps and discrepancies between men and women in who holds leadership positions still exist in nursing as they do in nearly every other professional field (U.S. Census Bureau 2). Studies have repeatedly shown that men are most commonly found in the highest paying and least compassion-based subspecialty of nursing, as certified registered nurse anesthetists (CRNA), with 41 percent of nurse anesthetists in the year 2011 identifying as male (U.S. Census Bureau 2,4). Research into the career paths of male nurses has also shown that they are the promoted and given raises faster than their female colleagues and that pay gaps between male and female nurses tend to become greater as the training and skill level of the nurse grows, with the largest pay gap

being observed between male and female nurse practitioners (U.S. Census Bureau 5). This is particularly disheartening when one considers both the original intentions of nursing, in part, as a field to empower women outside of the home, but also when one considers that women are not enticed into male dominated fields with similar incentives. This speaks to the subtle opinion in much of society that nursing, the work of women, can be legitimized only when it has also become the work of men. For this reason an increasing focus around the modern topic of gender and nursing in greater society is not how it can remain true to its compassion-based models of care and its history as an empowering space for women, but instead about how the stigmas around nursing can be reduced to make it seem a gender-neutral space for men.

In the modern day, political and social pressures to recognize and value the work that nurses do has resulted in movements to increase autonomy for nurses and to value the unique work they do, especially around issues of compassionate medicine and palliative care and hospice measures. Still though, nurses remain woefully underpaid and exist in a medical culture that delegitimizes their work and continues to enforce sexist and misguided preconceptions left over from strict Victorian cultural norms. As Frances Ward details in her accounts of her career as a nurse practitioner in her memoir, *The Door of Last Resort*, even in a modern Western culture of medicine that is increasingly coming to begrudgingly recognize the importance of medical teams, nurse practitioners remain essentially invisible, despite overseeing many of the very hands on aspects of patient care (Ward xiv). Until society begins to move away from the draconian worldviews of a physician-

centered model of healthcare, there will be no real or effective change to the modern American healthcare system. Due to the growth of nursing within the patriarchal and hierarchical setting of institutionalized medicine and, specifically the male controlled hospital, nurses have never fully been able to control their profession as they should be able to (Glass and Brand 33). While nurses have long advocated for crucial social and medical movements, their work has remained largely ignored in the greater medical community. An increasing, and promising, exception to this is the American End-of-Life Movement, as hospice and palliative care services increasingly become larger parts of many mainstream medical treatments. However, even in this movement the acceptance of these nursing philosophies and modes of treatment has been slower than many within the nursing and compassionate-medical care communities would like, and has only begun to truly become incorporated into mainstream medicine as physicians have decided to endorse it. This creates the illusion of choice for many patients and continues to prevent important and desired medical care from happening because nurses' voices, particularly those of nurse practitioners who have the equivalent academic training to physicians and have been shown to be at least as effective as physicians, are ignored and devalued (Summers and Summers xix). Until this trend is altered, patient care will continue to suffer. The view that nurses need constant male supervision or else tragic medical errors will immediately result is based in pure stereotype and not in fact and is damaging to the field of medicine not only by limiting the available number of medical practitioners, but also by limiting patient choice by forcing patient into having to partake in one philosophy of medical care

developed from one very limited perspective. As the hospice and palliative care movements show, medical practice and treatment can only be improved upon by opening medicine up to increased perspectives and treating various ideas and philosophies with respect and an open mind. This will only occur once medicine begins to truly address and recognize its gendered history and the ways in which this has shaped the field.

Nursing as a profession has seen a very dynamic and rich history and has help to, both directly and indirectly, shape medicine as a whole. The existence, and continued existence, of nursing at all is remarkable when one considers that the field is not only one of the few fields comprised primarily of women for most of its history, but it is also a field that allowed women beginning in the mid-1800s to begin actively engaging in the sciences, something that many women still struggle with in other disciplines. Perhaps even more important about the growth of the professional field of nursing as a women's led movement is that nurses have continuously fought to stick to the fundamental beliefs and practices of the discipline around compassionate and patient directed care, while still working to remain relevant and to ensure nursing is serving the populations with which it interacts to the best of its ability. As medicine continues to rapidly evolve, especially as America's needs for strong primary and geriatric care continue to increase, it will largely fall to nurses and compassion-based medicine to address the issues that will arise in a way that will be both productive for society and medicine as whole, and meaningful and successful for individual patients. The large-scale medical issues facing America today are too complex and intersecting in various facets of life,

combining issues such as industrialization, socioeconomic status, genetics, class, and race, among countless other factors, to continue to approach questions of medicine from one narrow minded and limited patriarchal prospective of problem solving. Nurses has long been advocating for a medical system based around the principles of holism and treating patients as people and not diseases. It is time that society stops ignoring their expertise in these issues and allowing gendered stigmas and stereotypes around the ways in which women are expected to act and behave to limit society from looking outside of cure-based medicine, to create a truly dynamic and successful medical system.

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